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Chemist&Druggist
The Newsweekly for Pharmacy

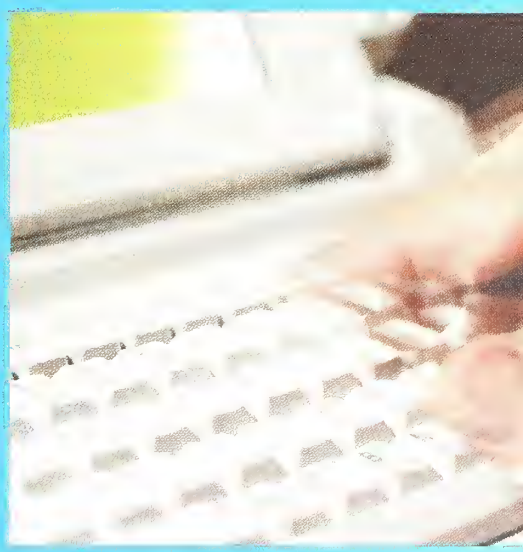
11 May 2002

Scottish Exec told to consult over payments

Query over ownership of RPSGB's assets

Boots creates Net portal for practitioners

Is ETP still on course for 2004 target?

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This week

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CSA told to consult on payment methods

The Scottish Audit Committee has recommended the Common Services Agency consult "extensively" with pharmacists over the introduction of the new computerised payment system.

It was also "surprised" that the Scottish Pharmaceutical General Council had not been consulted about implementation of a payment verification system that will operate across primary care in Scotland.

In its 'Overview of the NHS in Scotland 2000/2001', the Audit Committee notes considerable delays in payments, due partly to the introduction of the electronic payment system. The CSA's use of estimated payments over this period and the cash-flow problems pharmacists faced, it adds, presented financial risks.

"It is crucial the current system is robust enough to handle ongoing development and ensure that similar delays are avoided in future," it stresses. "We therefore recommend that the CSA should extensively consult with pharmacists during the ongoing development of the new computerised payment system, within a specific and given time-scale set by the payment."

Frank Owens: glad the Committee has recognised difficulties

In terms of the payment verification protocols, the Committee recommended the CSA establish communications with SPGC regarding the partnership agreements for payments.

The Audit Committee was alerted to the problems faced by pharmacy contractors when Frank Owens, chairman of the Scottish Pharmaceutical General Council, gave evidence on March 5 (*C&D, March 16 p4*). Mr Owens had told the Committee there was a need to restore contractors' faith in the payment system.

Following publication of the Committee's report last week, Mr Owens said: "I am glad that the Committee has publicly recognised the difficulties which the system of estimated payments caused for contractors. I encourage the CSA to follow the recommendations in the report and I look forward to working with the CSA as the Committee has recommended."

Despite the payment timetable having returned to 'normal', Mr Owens is concerned that a "significant number of problems" remain with the pricing system.

"There is an ongoing lack of transparency in the manner in which payments are made," he said. "Additionally, SPGC estimates that the error rate in prescription pricing is double what it was before implementation of the OCR system. Pharmacy contractors deserve better than this."

Another point raised by SPGC was that contractors currently face increased accountancy fees. This is attributed directly to the increased work brought on by the PSD pricing problems.

For more information:

www.scottish.parliament.uk/official_report/cttee-02/aur02-04-03

Power to empower patients

Health professionals must act to empower patients in the move towards self care, Dr Simon Fradd has argued.

Dr Fradd, chairman of the Doctor Patient Partnership, said pharmacists have a key role with increased access to medicines through pharmacies. However, he was concerned supplementary prescribing will be a "double-edged sword, as it may actually be a low volume activity" for pharmacists.

Dr Fradd was addressing a meeting last week of the All Party Parliamentary Group on Primary Care and Public Health – supported by the Proprietary Association of Great Britain.

A key factor in increasing self care is access to information, he said. But patient information leaflets should be reconsidered as they are "totally inadequate and do more to protect the [pharmaceutical] industry with legal caveats than inform the public about what they can do with the drugs".

There was also a "glaring weakness" in the NHS Plan, which should have included a requirement to make health awareness part of the national curriculum for schoolchildren.

Dr Fradd warned he had "grave concerns" about a two-tier system developing with the transfer of medicines from Prescription to over the counter status. Although it meant faster access to those who can afford the OTC medicines, others will still need to spend time sitting in GPs waiting rooms.

WALES

Second pharmacist chosen to chair LHB

A second pharmacist has been proposed to chair a local health board in Wales.

Chris Martin's appointment as chair of the Pembrokeshire LHB will officially take effect from April 1, 2003, subject to final approval.

Mr Martin, a proprietor in Dyfed, currently chairs the Local Health Group, having done so since August last year.

Before that, he served as vice-chairman.

"We will be almost fully fledged by July," he said last week. "We will then have to choose the new chief executive and get the shadow board up and running by January.

Last month the Welsh Assembly proposed that another pharmacist, Barry Harrison, chair the Flintshire LHB (*C&D, April 27 p9*).

Support for children's medicines plan

The Royal Pharmaceutical Society has welcomed European Commission proposals to improve availability of children's medicines.

In particular, the Society believes licensed formulations should be authorised across all EU countries and made available to health care professionals. At present, products authorised in other European countries, but not in the UK, must be imported as unlicensed medicines or prepared extemporancously.

The Society also supports incentives for drug companies to research paediatric formulations, such as a supporting fund.

Another way of collecting safety data would be to record when drugs had the required effect with little or no toxicity. A central database is an "excellent idea" that should have priority.

A riotous assembly? The Mayfair Pharmacy in central London was boarded up in anticipation of May Day protests, but managed to escape damage. Owner Leon Ungar said the main procession passed without incident, although the 'revelries' later were a bit more of a concern. Pharmacy services were provided throughout, but customers had to knock to gain access. This photo was taken before the boards were put up and eagle eyed viewers would have been hard pressed to recognise the shop when it was used a backdrop for an interview on that night's 'Newsnight' on BBC2, added Mr Ungar

RPSGB

Pharmacists do not 'own' the Society, say experts

Pharmacists have no claim on the Royal Pharmaceutical Society's assets, either collectively or individually.

A letter of advice from lawyers has confirmed that the Society, as a corporation, is the "legal and beneficial owner" of all its assets, except any held on specific trusts. As a legal entity, the corporation is separate from its members.

Some pharmacists are concerned that if the Society were to split its regulatory and professional functions, a new body could claim assets such as the headquarters building and president's flat, leaving members with no control over what they had funded for several years.

The legal opinion explains that if the Society was wound up, the Charter does not allow for property to be distributed to members. But it might be possible for assets to pass to the Crown as *bona vacantia* (goods without an apparent owner). The Crown would then have power to transfer the property to another body with similar objectives.

Oxford pharmaceutical consultant Mark Walker wrote an open letter to the president asking who authorised the Society to try to prove that membership does not own its assets. He is concerned that the Council and membership were not consulted.

He wrote: "We need to know if Council officers have acted without informing either Council or members; or if Society staff have acted without informing the officers.

"The president's flat incident provoked rumour and speculation that undermined trust in the Society's leadership. Is history repeating itself?"

Mr Walker is standing for election as an auditor of the Society.

Assets worth £11 million

● The Royal Pharmaceutical Society's net assets were £11.01 million at December 31, 2001. This is up 4.5 per cent on the previous year which stood at £10.53m. Fixed assets at the end of 2001 were £7.25m. Net current assets, after creditors amounts, were £4.61m. Within this, freehold property was valued at £4.27m, plant and machinery at £1.84m, and office equipment at £1.41m. The Society's total income for the year was £21.374m compared to the previous year's £20.51m. Expenditure was slightly down in 2001 from £21.71m to £20.62m. Employee costs were relatively stable at £9.14m, although average staff numbers fell from 242 to 224. Among the secretary and registrar's and directors' remuneration grouping, one person was paid between £110,000 and £115,000, while two others were paid between £100,001 and £105,000.

The Society's full accounts are published on its website.

NPA training number

The telephone number of Sukhjit Grewal, pharmacist training officer at the National Training Association, is 01732 832161 ext 286 and not as appeared in the *C&D* education feature of April 13 p32.

Society's Scottish election

There are ten candidates standing for six places in this year's election to the Scottish Executive of the Royal Pharmaceutical Society.

The candidates are:

- Professor Christine Bond, of the University of Aberdeen, and consultant in pharmaceutical public health
- John Duncan, an employee community pharmacist in Perth
- Maurice Hickey, a community pharmacy contractor in Forres, Morayshire, and member of Moray LHCC core management group
- Professor Claire Mackie, professor of pharmaceutical care and community pharmacy contractor
- Edward Mallinson, a specialist in pharmaceutical public health in Lanarkshire
- Rose Marie Parr, director of the Scottish Centre for Post Qualification Pharmaceutical Education
- Ronald Shiels, pharmacy proprietor in Inverness, and Highland PCC chairman
- David Thomson, director of pharmacy, primary care trust, Greater Glasgow
- Angela Timoney, specialist in pharmaceutical public health, NHS Tayside
- Noel Wicks, community pharmacy proprietor in Stirling.

Ballot papers are being circulated to pharmacists in Scotland and must be returned by 4pm on June 12.

For more information:
info@rpsis.com
Tel: 0131 556 4386

Definition of dispensing services

New regulations incorporate a definition of dispensing services to take account of doctors providing pharmaceutical services under a pilot scheme. The main purpose of the regulations is to outline the increase in prescription charges from April 1.

For more information:
The NHS (Charges for Drugs and Appliances) Amendment Regulations 2002 (SI No 548; The Stationery Office).

Global health care solutions

Drug companies should not be used as scapegoats to cover up international social failures and global community problems, says a new report.

Pharmaceutical advances in the 21st century could increase life expectancy to over 100 years in Europe and the USA.

But a report from the School of Pharmacy, University of London, claims that this progress will be lost if failures to improve overall world health promote global conflict.

The report, *The pharmaceutical industry, pharmacy and world health*, suggests that undermining the patents system could adversely affect investment in medicines research.

David Taylor, the school's professor of practice and policy, believes there is no guarantee that poor populations will benefit from generic competition-based approaches.

"A more radical reform would be to extend pharmaceutical patent lives to, say, 30 years, but require global patent holders to supply the poorest communities at cost, and have regulatory arrangements strong enough to ensure that minimal cost medicine supplies do not leak back to undermine richer markets," he said.

The report calls for global partnerships between research based companies and governments.

Price discrimination could be backed by global and national health funding systems, ensuring there is enough money to pay for effective treatments and the services needed for their delivery.

MULTIPLES

Boots names charity duo

Boots has announced that its charity partners for the current financial year will be Breast Cancer Care and WellBeing, the fundraising and research arm of the Royal College of Obstetricians and Gynaecologists.

The company will work with the charities to promote health-related advice and information. Boots expects to raise over £500,000 for the organisations. Last year it made over £175,000 for WellBeing and has raised over £840,000 in the past five years for Breast Cancer Care.

Boots is running health-related campaigns and has published a free booklet on women's health.

Catherine O'Brien (left) has been appointed the new secretary of the Welsh Executive of the Royal Pharmaceutical Society. She previously worked as an area manager for the Co-op Pharmacy in South Wales. "Pharmacists could make a much greater contribution to primary health services in Wales, particularly in medicines management," she said. "It is our remit to work towards these professional services being available as common practice throughout Wales." Ms O'Brien, pictured with Andrea Robinson, chair of the Welsh Executive, will begin her post full-time by the end of June

MEDICINES

UK Sport issues drug guidelines

A leading sports agency has produced information for health care professionals, detailing which medicines athletes participating in sports events are permitted to take.

The Government agency UK Sport issued a series of leaflets on prohibited substances at its conference, 'The Responsibilities of Health Care Professions' which was held on April 30 in London.

Topics covered include herbal and nutritional substances, narcotic analgesics, nandrolone, diuretics, anabolic androgenic steroids and peptide hormones.

The leaflets draw attention to how and why competitors may use the drugs to improve performance the harm caused by the drugs and which medicines contain the substances.

For more information:

www.uksport.gov.uk

POLICY

Tesco calls on women to promote men's health

Tesco is to encourage women to help improve the health of men.

As part of Men's Health Week (June 10-16), Tesco stores will be promoting a new booklet, *An eye for men's health*.

This covers issues such as why men ignore their health, warning signs of ill health and various health conditions.

Launching the booklet, Dr Howard Stoate MP, chairman of the All Party Men's Health Group, said: "Men are extremely reluctant to go to their GP or pharmacist when they've got a problem or to discuss their health with their family. As a result, a lot of men aren't getting the medical help they need.

"That's why I'm asking wives and partners to get more involved in men's health. We need to encourage men to take greater responsibility for their own health and well-being and men's wives and partners are uniquely well placed to help them do that."

Questiontime

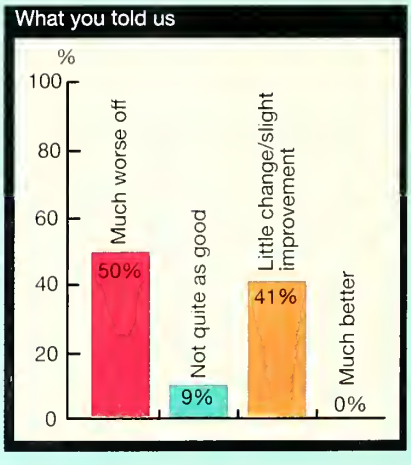
in association with UniChem

Last week we asked you: Four months in, how would you rate +Plus, GSK's new trading scheme, compared to the previous agency scheme. You replied (see right):

This week's question: If the Royal Pharmaceutical Society was dissolved, how do you think its assets should be treated?

- Transferred in their entirety to the new regulatory body
- Transferred in their entirety to a new membership organisation
- Split between a new regulatory body/membership body
- Market value realised and divided among RPSGB members
- Transferred to the Crown
- Other option

You can record your vote on our website: *www.dotpharmacy.com* Question time appears on the home page. Select your answer and then click on the "vote" box. Your answer is automatically collated. You have until noon on May 14 to cast your vote. We will publish the results in *C&D*, May 18.



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CONTRAINDICATIONS: Hypersensitivity to the constituents. Avoid use in pregnancy and lactation. **DRUG INTERACTIONS:** To date there are no known interactions. As with other antihistamines avoid excessive alcohol consumption.
SIDE EFFECTS: Mild and transient drowsiness, headache, dizziness, agitation, dry mouth and gastrointestinal discomfort. Convulsions have very rarely been reported.
PACKAGING/PRICE: Zirtek Allergy: Pack of 14 tablets = £7.95 Retail. Zirtek Allergy Relief: Pack of 7 tablets= £4.45 Retail.
LEGAL CATEGORY: Zirtek Allergy: P. Zirtek Allergy Relief: GSL
MARKETING AUTHORISATION NUMBER: PL 08972/0032
MARKETED BY: UCB Pharma Limited, Watford, Herts, WD18 0UH.
FOR FURTHER INFORMATION PLEASE CONTACT: UCB Pharma Limited, UCB House, 3 George Street, Watford, Herts, WD18 0UH. Telephone (01923) 211811. Facsimile (01923) 229002.
DATE OF PREPARATION: April 2002
UCB-ZAR-02-109

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'We need a medication error databank'

Healthcare professionals need a more rigorous national system for reporting medication errors. But first they need to overcome a culture of mistrust, as Adrienne de Mont reports

Healthcare professionals need a national system for reporting medication errors in the NHS so everyone can share information and learn from others, according to Professor David Upton, chief pharmacist, University Hospitals of Leicester NHS Trust.

Risk management strategies could then be based on a wide experience.

Medication error reporting is still mainly based in hospitals and it will be a huge challenge to adapt and roll out these models to community pharmacy, he told delegates at a College of Pharmacy Practice study day in London.

The community environment is much more competitive and commercially sensitive, with pharmacists coy about disclosing information that could reduce patient confidence.

"Would Boots and Lloydspharmacy be likely to compare their error rates and bounce ideas off each other?" he asked.

A nationally co-ordinated quantitative reporting scheme would also make manufacturers more aware of how their packaging could lead to errors. Companies are often more concerned about corporate livery than whether the medicines are easily distinguishable on shelf. The Medicines Control Agency checks that new packaging meets legal requirements but does not "risk assess" it, and Professor Upton hopes the new National Patient Safety Agency will vet packs before products are approved for licensing.

He favours no-blame error reporting, but said it was important to distinguish this from poor performance. He would be less likely to condone an error if a person committed it twice.

"We need to know the root of a problem if we are to give a satisfactory response to it," he said. If a pharmacist picks up the wrong medicine, he needs to know whether it is because the names are similar, the packs look the same, or the lighting is bad in the shop. When products are introduced, pharmacists could anticipate potential risks by separating packs from others with a similar appearance, or even buying from other manufacturers.

With the introduction of patients' own drugs schemes, hospital pharmacies are picking up more dispensing errors in community practice. One of his local PCTs runs a scheme in which the information is fed back to the pharmacies concerned. Reactions varied from blaming it on the locum to one pharmacist coming into the hospital and apologising directly to the patient. Professor Upton advocated a system somewhere between the two, in which pharmacists took reported errors on board and said "this is what we've done to stop them happening again".

Patients' own drug schemes are also creating a new type of error on discharge. Nurses often have no time to check whether the medicines were still valid and just tip the contents of the patient's locker into a bag. Professor Upton thought these schemes should not operate unless pharmacists or trained technicians are available to check the medicines before patients take them home.

Automation has significantly reduced medication errors in hospital dispensing, but human errors still occur and robots are probably not an option for community pharmacy, he said.

A common error in hospitals is giving a drug to the wrong patient, and Professor Upton suggested patients should be bar coded and "swiped" before being given the matching drug. The technology is available, but healthcare is lagging behind other industries in making use of it.

He claimed nurses' knowledge of drug administration is so inadequate they should be replaced by a dedicated trained workforce that was unlikely to be interrupted by phones ringing and the patient's relatives asking for information.

Steve Eastham, Boots' head of clinical governance, explained his company's dispensing incident management scheme in which pharmacists are required to record dispensing mistakes, including possible causes and "near misses" that never reach the patient. Boots has amassed large amounts of information, which is helping to formulate risk management strategies and changing attitudes to give more emphasis to patient safety.

Mr Eastham said the company is working with the Royal Pharmaceutical Society, the Department of Health and other agencies so experience gained could be communicated to others.

Dr Bryony Dean, director, academic pharmacy unit, Hammersmith Hospitals NHS Trust, explained how Reason's "accident causation model" could be applied to prescribing errors. This model is based on the assumption that "active failures" by prescribing doctors are largely the result of the conditions in which they work. These "error-producing conditions" include high workload, inadequate knowledge and a stressful environment. "Latent conditions" stem from decisions taken by people not directly in the workplace and lead to conditions in which unsafe acts occur.

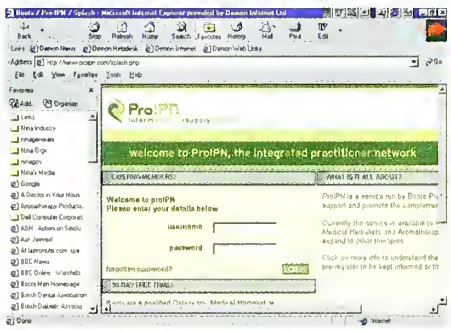
Dr Dean said one of the latent conditions in prescribing errors was the low priority given to teaching prescribing in medical schools. Doctors in hospitals tend to rely on pharmacists to pick up their errors, and pharmacists often put things right without feeding the information back.

IT

Boots' new Net portal targets practitioners

The Boots Company has launched an internet portal aimed at creating a networking platform for mainstream and complementary healthcare practitioners. It is called ProIPN, the Integrated Practitioner Network.

The site, *www.proipn.com*, is envisaged as a forum for inter-professional ideas exchange and to help professional and personal development. Its aim is to increase professional standards and build public confidence.



Access is restricted to practitioners who are registered with a professional regulatory body and the current membership is said to be in the dozens. Interested practitioners can try out the site during a 30-day free trail period.

Unlike its other internet ventures, *wellbeing.com* and *handbag.com*, Boots operates the site on its own.

A spokesman for Boots said that, while pharmacists were welcome to join, proIPN was not intended as a mainstream vehicle for them.

For a membership fee of just over £1 per week the site offers:

- free access to a number of databases, eg eMIMS
- unique articles from leading professionals, along with daily news updates on complementary medicine and general health issues
- client/patient factsheets
- access to CPD courses online or via CD-ROM (charged at between £20 and £30 each)
- a one-stop shop for all professional supplies, open for orders 24 hours a day, 365 days a year. Deliveries are usually made within three working days
- discounts on various materials eg 15 per cent off *Elsevier Scienc*

"There are a lot of interesting things we are keen to learn about," said the spokesman, adding that ProIPN may carry product-related opportunities in future.

For more information:

www.proipn.com
helpdesk@proipn.com

INDUSTRY

T&R buys Galen brands

Thornton & Ross has acquired several cough & cold medicines and iron supplements from Galen Ltd for an undisclosed sum.

The products concerned are Galpseud (linctus and tablets), Galpseud Plus (linctus), Galenphol (linctus, paediatric and strong), Galcodine (linctus & paediatric), Galfer (capsules and syrup), Galfer FA (capsules).

T&R's chief executive, Dieno George, said the company had wanted to enter the market for some time and was trying to build up its cough & cold franchise.

IT

Park launches space-saving hardware

Park Systems has launched Genesis, a range of space-saving hardware to accompany its PMR and EPoS software systems.

The Genesis computer combines the base unit and the monitor in one compact component, said to occupy less bench space than a traditional keyboard.

The system features a 1GHz Pentium processor and 15inch flat-screen monitor. It includes a DVD drive, 20Gb hard drive and 128Mb RAM, is network-ready and runs on the latest Windows version, Windows XP. A range of printers, keyboards and scanners can be added to complete the system.

The Genesis hardware can ru both the Park PMR and PharmaciePoS systems. Prices start from £49 per month plus VAT for a Genesis PMR systen (hardware and software) and £ per month for a PharmaciePoS system (hardware and software)

Park is also due to launch PMR and Epos software in t next few weeks, with one o the new features expecte to be an interactive checking of prescriptio medicines and OTC products.

For more information:

info@parksystems.net
Tel: 0151-2892233

INDUSTRY

Powderject's £32m smallpox contract under review

PowderJect Pharmaceuticals' £32 million government contract to supply 16 million doses of the smallpox vaccine is being reviewed by the National Audit Office.

A spokesman for the NAO said it was "reviewing the arrangements for awarding the contract" but added it was too early to say whether a full report would be produced.

The spokesman said the review timetable was "totally dependent on what we find".

Powderject won the contract in April and transfer of vaccine production was arranged under a strategic collaboration agreement with Danish company Bavarian Nordic.

The agreement saw PowderJect take a 5.6 per cent stake in Bavarian Nordic by acquiring 200,000 shares for £1.5m.

The Department of Health was criticised for the way the contract had been awarded amid claims of favouritism. Pointing out that PowderJect's chairman and chief executive, Paul Drayson, had made cash donations to the Labour Party, the national press reported that competitors were complaining they had not been given the chance to bid for the contract.

But the DoH justified its decision not to go to tender by stressing it had entered discussions with six companie

A DoH spokesman insisted PowderJect had been the only company able to fulfil the two main criteria. He explained th the vaccine had to be for the Lister strain of the disease, w is predominant on this side o Atlantic, and had to be availab quickly.

The contract is due to run 12 months.

Lloydspharmacy achieves company-wide IiP status

Lloydspharmacy has been awarded Investors in People (IiP) status for the whole company, including all branches, regional offices and its head office.

The award recognises the multiple's consistent high level of training and best practice.

Two-hundred Lloydspharmacy employees were interview by the IiP panel, which also travelled to all regional offices and branches in three regions as part of a week-long assessment. Pharmacies in the other regions were contacted by telephone.

"We are thrilled at securing IiP first time round and it is something we will be celebrating across the company.

"In recent years we have introduced many changes and improvements to our business from IT, customer care, services and best practice initiatives which have required everyone to adapt and take on new challenges," said managing director, Mike Ward.

Lloydspharmacy directors Mike Ward (left) and Steve Howard (centre) are presented with the Investors In People award by Peter Miller, human resource advisor at Coventry and Warwickshire Chamber of Commerce

IiP status has to be re-recognised every three years and only eight community pharmacy organisations have achieved the prestigious status, including Moss Pharmacy (HR), Boots the Chemists (corporate) and National Co-operative Chemists (corporate).

Coming Events

MAY 13

East Kent Branch, RPSGB, *Developments in Local Pharmaceutical Services*, QEQM Hospital, Margate, 7.30pm for 8pm

MAY 14

Moray & Banff and Northern Scottish Branch, RPSGB, *RPSGB Modernisation*, Laichmoray Hotel, Elgin, 7PM

Slough Branch, RPSGB *New treatments in dermatology*, Postgraduate Centre, Wexham Park Hospital, Slough, 7.15pm

Oxfordshire branch, RPSGB *Giving best travel advice*, Postgraduate Centre, John Radcliffe Hospital, Oxford, 7.30pm

NICPPET *Risk management*, Killyhevlin Hotel, Enniskillen, 7pm to 10pm

MAY 16

Weald of Kent Branch, RPSGB *Electronic Transfer of Prescriptions*, Ian Shepherd, The Jarvis International Hotel, Pembury, 7.30pm for 8.15pm.

NICPPET *Health economics*, NICPPET Resource Centre, School of Pharmacy, Belfast, 10am to 5pm.

New name

Medie-Aid, nebulisers and compressor products manufacturer, becomes Profile Human Systems from May 10. The aim of the name change is to help develop international business for both Medie-Aid and parent company Profile Therapeutics, and to avoid confusion in the US where a health insurer operates under the name Medicaid.

Bristol-Myers Squibb and Eli-Lilly both forced to issue profit warnings

Pharmaceutical giants Bristol-Myers Squibb and Eli Lilly have issued profit warnings.

Lilly said delays in the launch of two products had left it expecting earnings per share for the full-year to be between $2.60 and $2.65 (£1.77-£1.81). In January Lilly predicted earnings per share for 2002 would be around $2.70/$2.80.

The company also expects roughly flat sales growth for the current financial year and a decline in its gross margin of between 1 and 1.5 per cent. Next year Lilly expects double digit earnings per share growth.

Meanwhile BMS reported a 7 per cent decrease in sales for the first quarter to $4.3 billion and a 30 per cent reduction in pre-tax profits to $1.2.

However, the company expects its earnings per share to be between $1.69 and $1.81 for the full year.

Comment
from the Editor

Investors in People awards recognise best practice and a high level of training throughout a company. Lloydspharmacy is the latest in the pharmacy sector to achieve this and joins a list including Boots, Moss, Day Lewis and the National Co-op and smaller outfits like Badhams, Murrays, Weldricks and Barry Shooter Pharmacies.Those who dismiss such schemes as "management gone mad" are missing the point. The terminology and focus in healthcare might be a bit different (the NHS calls it clinical governance), but the desired outcome is the same – a validated quality service for customers.

At the moment there is no quality programme specifically for community pharmacy in the UK. However, much might be learnt from one operated by the Pharmacy Guild of Australia. In the late 1990s Australian pharmacists faced challenges from other retailers, and reviews under the Federal Government's competition policy of pharmacy ownership and the Pharmacy medicines category. Following consumer research the PGA responded with a strategy to raise standards of customer service in pharmacies across the country. The work culminated in the Quality Care Pharmacy Programme, with standards to achieve in retail, business and professional areas. The first pharmacy was accredited for three years in November 1998. By the end of January this year over 1,800 pharmacies had been accredited (at $7,500 each), and 4,747 o a possible 4,925 pharmacies had purchased programme materials (for details visit *www.qcpp.com*).

The icing on the cake is that the Australian government ha made available $50 million in financial incentives over five years to encourage pharmacies to gain QCPP accreditation. The threats from the competition policy reviews have been seen off in view of the public benefit being derived from the introduction of quality assurance in the services pharmacies provide. Do we have a similar vision in the UK?

At the moment there is no quality programme specifically for community pharmacy in the UK

Yourviews

The Hull Branch of the Royal Pharmaceutical Society is repeating last year's motion at the RPSGB's Branch Representatives Meeting. Andrew Hersom, branch secretary, explains wh

Hull insists on transparency

The RPSGB Council rejected Hull's 2001 motion to the Branch Representatives Meeting that "the Society should provide a more transparent set of accounts, and accountability for members to monitor income and expenditure with an enhanced and more public role for the auditors".

This was claimed to be unnecessary as robust internal controls – professional accountants employed by Council reporting to the Audit Committee – were in place. Our local branch committee has sent and received numerous letters since then, and the secretary and registrar has spoken at a branch meeting, but we remain unconvinced.

The Society's accounts for 2001 have just been published, and they highlight why we proposed the motion in the first place. The accounts are hard to decipher. There is no detail on some of the large sums being spent on behalf of members. For example, what was the cost of furnishing the President's flat? What was the annual service charge?

When we re-submitted the motion for the 2002 BRM we wrote to all candidates to the Society's Council. We asked them two questions: did they support our motion on better financial transparency and enhanced role for the auditors; and, if elected, what would they do to make sure this motion was implemented?

Nearly all expressed support for both questions. Interestingly, the candidates for auditor also responded. Members may be surprised to learn that:

- Auditors only have a two hour annual meeting despite having requested more frequent meetings
- They see the same accounts as ordinary members
- Their questions are not always helpfully answered
- Supportive evidence, eg Committee minutes approving spending, is not always available
- Some questions are blocked on the basis that they are "now covered by the Audit Committee"
- The accounts change format from one year to the next making comparisons difficult
- The auditors lack any real power as their only recourse is failing to qualify the accounts

As a branch we fully support the need for modernisation and CPD implementation, and know that money will need to be spent. But we do question how much is being spent and how well it is being managed.

We are entitled to know that commercial (ie non-fee) incom spent appropriately. It seems t argued in some quarters that t auditors should only be involv in accounts relating to fee inco and expenditure. But if the commercial income is manage properly then it may be that o fees could actually fall quite substantially.

HOSPITAL REPORT

Too many cooks ...

Why is pharmacy so often sidelined as a healthcare profession? For the same reason that many others are overlooked: we are not doctors or nurses. But is it just that? The plethora of groups speaking for different sectors of pharmacy confuses our politicians.

If I, as an outsider, want to speak to "pharmacists" about prescribing, do I speak to the RPSGB, the SPGC, the NPA or the Guild of Healthcare Pharmacists?

I was disappointed that a GHP representative was not at the launch of 'The Right Medicine'. Both the SPGC and the RPSGB in Scotland were on the top table with the chief pharmacist (this was, perhaps, appropriate because there is a disappointing lack of hospital focus within the strategy).

However, it would be an advantage to have a forum at which the various pharmacy groups are represented and which could act as the main gateway for anyone to contact "pharmacy".

The plethora of groups speaking to different sectors of pharmacy confuses our politicians

The forum would comprise the main players and the smaller groups which rarely have any input to national policies.

Technicians also have to be represented, as many of the proposals for pharmacists need the availability of technicians to take on roles that pharmacists intend to shed. What would this forum actually do? There is a plethora of consultation documents from government. It makes sense to have one response from all of the pharmacy organisations rather than one apiece. This does not mean that organisations cannot submit their own response, but it should mean that everyone is singing from the same hymn sheet!

Contributed by a senior hospital pharmacist

TOPICAL REFLECTIONS

Home health monitoring ready to take off

It has taken many years for glucose blood testing meters to become the accepted standard for diabetics but this has now been achieved, despite the refusal of the NHS to allow for the reimbursement of meters under the Tariff.

Now another blood testing market could be opened to similar forces with the availability on prescription of CoaguChek S test strips for the estimation of prothrombin time and INR status for patients on anticoagulation therapy.

The meter, according to Roche Diagnostics, will display both the prothrombin time and INR status in one minute. (*C&D Scriptlines, May 4 p26*).

The drawback to home testing for INR is the price of that meter, which has to be purchased from Roche.

At £399 plus VAT the meter is out of reach of most of my warfarin patients but, as usage increases, so the price will fall and, in a few years time, I predict that anticoagulation meters will be as common as glucose blood meters are today.

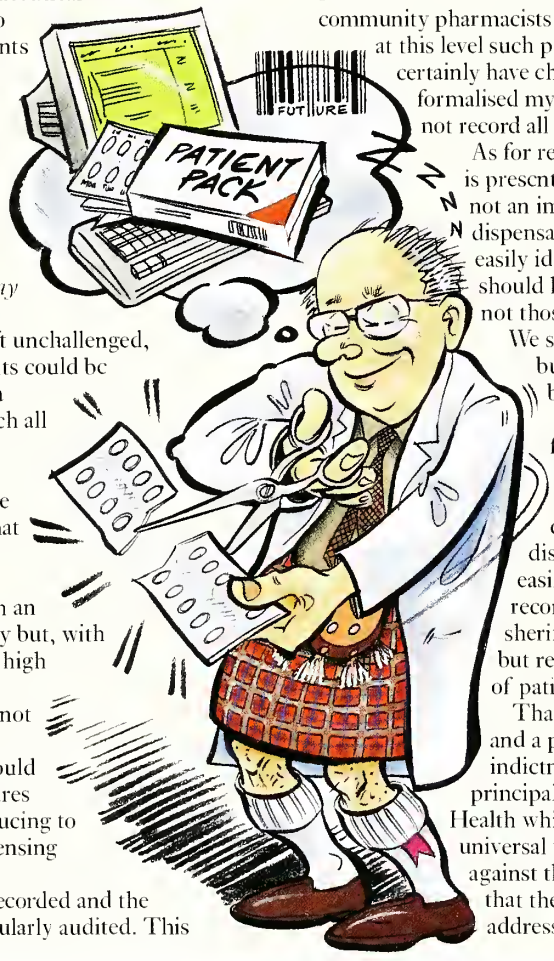
Then there is blood lipid monitoring for patients taking statins or controlled by diet for the prevention of coronary heart disease. Far better that these patients have access to easy home monitoring facilities than the cumbersome process of attending the surgery, sending blood to a laboratory and then waiting days for the result.

Within a few years I can see meters being available that will enable home health monitoring for the whole family.

These represent a possible prescription for hypochondria, but they will also be an opportunity to banish the mystique of medicine and empower patients to take responsibility for looking after their own health.

Right in principle, difficult in practice

The National Pharmaceutical Association is right to challenge the comments from the sheriff of a Scottish court that pharmacists should have in place systems for reconciling drugs ordered on prescription against those actually dispensed (*C&D, May 4 p6*). The NPA is concerned that, if left unchallenged, the sheriff's comments could be construed as setting a standard against which all dispensing should be measured.



As a member of the NPA I am grateful that the Association is challenging the establishment of such an onerous responsibility but, with clinical governance a high national priority, the sheriff's remarks cannot be totally dismissed.

All pharmacies should have written procedures in place aimed at reducing to a minimum any dispensing errors.

Errors should be recorded and the system should be regularly audited. This should be the bare minimum, but I doubt if many community pharmacists can, hand on heart, claim at this level such protocols are in place. I certainly have changed my procedures and formalised my checking but, as yet, I do not record all errors made.

As for reconciling drug usage, that is presently impracticable but it is not an impossible dream. Present dispensary computer systems can easily identify those drugs which should have been dispensed, but not those supplied.

We still regularly dispense from bulk, and the rules still mean blister packs get the snip.

But if all dispensing was from patient packs then the use of barcode readers linked though the computer into the dispensing procedure could easily enable the reconciliation recommended by the Scottish sheriff. The solution is simple but requires the universal usage of patient packs.

That I am still using bulk packs and a pair of scissors is an indictment of official inertia, principally at the Department of Health which refuses to fund the universal use of patient packs. It is against this intransigent officialdom that the sheriff should really be addressing his criticisms.

Sanatogen® and – restructuring

Pharmacists need to fight against inroads by supermarkets into the supplements market. Sanatogen and Redoxon are perfect weapons

The Sanatogen range

Sanatogen® Gold A to Z®

- Number 1 branded multivitamin[1]
- The Sanatogen Gold Standard
- The only A to Z product to contain Lutein, which helps to maintain healthy eyes and eyesight
- Contains Iron

Sanatogen® Vital 50+®

- The number 1 50+ supplement[1]
- With Ginkgo & Ginseng for vitality in mind and body

Sanatogen® ProNatal®

- The number 1 pregnancy supplement[1]
- With extra Folic Acid
- Helps build a healthy baby

Sanatogen® Childrens Range®

- Deliciously flavoured syrup, jellies or chewable tablets
- For healthy growth and development

The vitamins, minerals and supplements (VMS) category is the largest OTC category by value. This category represents a major opportunity for pharmacies. Over recent years supermarkets have gained a larger market share, primarily from the traditional high street pharmacy. It is imperative that pharmacies fight back and drive sales in this category.

Restructuring

The vitamins, minerals and supplements category remains a complicated and confusing area for both consumers and pharmacists.

Simplifying your range will lead to a greater fixture impact, reduced consumer confusion and will drive new users to enter the category.

At Roche Consumer Health we are committed to helping pharmacies grow their VMS categories. In order to increase sales in pharmacy we need to make it easier for the consumer to shop the fixture.

Tips for simplifying the VMS fixture

- **Pharmacist and Counter Assistant Recommendation**

Pharmacist intervention is crucial to the sales of the whole VMS category. For this reason it is recommended that the VMS fixture is located close to the prescription counter. This will help both pharmacists and counter assistants advise customers in this key category.

- **Block by Segment**

Block by segment to help consumers choose the right product for them. Roche Consumer Health has developed a merchandising system that allows the VMS category to be placed on fixture in clear benefit led blocks.

The sample plan demonstrates this with the following segments: Healthy Joints, Childrens, Multivitamins, Energy & Vitality, Immune System, Womens and Specialist.

- **Beacon Brands**

Use beacon brands, that is, those brands most easily recognised by the consumer. These beacon brands can be used to signpost the different segments in VMS: Sanatogen Gold A to Z for Multivitamins, and Redoxon for the Immune System segment.

- **Avoid an Overcrowded Fixture**

Range rationalisation should be undertaken to remove slow or redundant products. Remove brands with low consumer awareness.

Sanatogen® and Redoxon® in the future

Simplifying the fixture is key to the success of the VMS category. At Roche Consumer Health we have already tried to influence this process by restructuring both the Sanatogen and Redoxon ranges to drive growth.

Sanatogen and Redoxon are at the forefront of vitamin development. In order to remain the number 1[1] multivitamin and vitamin C brands respectively, both the Sanatogen and the Redoxon range will become more tightly focused and competitive in the future. They will be ranges that drive growth in your pharmacy and will innovate for the future.

1. Information Resources - Value sales 52 w/e 27 Jan - total chemists

The Benefits

The new streamlined ranges will: -

- Establish beacon brands and focus on products that can drive growth in pharmacy.
- Drive consumer penetration by making it easy to use a trusted brand.
- Make the fixture less cluttered, bring in new users and reduce confusion for the consumer.

Redoxon®
for growth

Use this planogram to help you remerchandise your VMS fixture. Stock key brands across the category, including beacon brands like Sanatogen and Redoxon. Block them by segment and avoid overcrowding to help consumers shop the fixture. Keep your product knowledge up to date

The Redoxon range

Redoxon® Double Action®

- Redoxon is the number 1 vitamin C brand[1]
- Double Action combines Vitamin C and Zinc which act in different but complementary ways to help support your natural defences
- Has a similar taste to Redoxon orange effervescent and chewable tablets but offers additional immune benefits

Redoxon® Slow Release®

- A Vitamin C supplement with micro-granules that slowly release this essential vitamin into your system over a period of 8 hours
- This steady supply is important due to the body's inability to store Vitamin C

Redoxon® Chew-C®

- A delicious and simple way to help support your body's natural defences

Sanatogen

If you have any queries please contact:
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E-mail: info@sanatogen-help.co.uk
Post: Sanatogen Freepost

Redoxon

If you have any queries please contact:
Freephone: 0800 093 2130
E-mail: info@redoxon-help.co.uk
Post: Redoxon Freepost

Ple@se e-mail your views to chemdrug@cmpinformation.com

Let accessibility be balanced against public health

In answer to Industry Viewpoint, "Does the NPA want a closed shop?" (*C&D, April 20, p15*) I have to ask: does the industry want a free-for-all? The answer to both questions, of course, is a resounding "no".

But consider this. There is more to this issue than "supply", and there is more than one Government policy (accessibility) involved. As medicines move to GSL, particularly now resale price maintenance is gone, supermarkets will increasingly tempt consumers to shop on price, not "added value".

Thus "accessibility" has to be balanced against the "public health" impact of deregulation – and that is precisely what is at the heart of the National Pharmaceutical Association's stance. It would be more productive if pharmacists and industry could work together on this – it is, after all, in our mutual interests.

For example, in my pharmacy we intervened when one of our regulars was purchasing an excess of OTC gastrointestinal remedies and, concerned about his symptoms, we referred him to his GP. The GP organised tests, an early oesophageal carcinoma was revealed and, post-surgery, a life has potentially been saved.

All of this was featured in *C&D*'s "local heroes" column in 1999–2000, and we went on to win a major industry-sponsored award as a result. If the products in question had been GSL, purchased outside pharmacy, none of this would have happened and the symptoms would have progressed too far (survival rates of those with late-detected oesophageal cancer are poor).

I have just returned from an all-too-brief break in the USA, where there is no Pharmacy category. There, the industry is having to take out prime-time TV advertising to warn consumers not to double-dose with interacting OTCs. And the strapline: not "ask your pharmacist" but "read the label". Is that a prospect we would welcome here?

Graham Phillips
St Albans

Live up to our claim as the experts

Xrayser comments (*C&D, April 13, p15*) that a more active approach to ADR reporting by pharmacists runs the risk of "scaring" the Medicines Control Agency into recommending that a P medicine should move to a POM.

If we could demonstrate our effectiveness at ADR reporting by increasing our proportion of the total number of reports received for POM, P and herbal medicines, it would help send a message that we can live up to the oft-repeated claim that we are the "experts in medicines".

The overwhelming majority of health interventions that pharmacists make are undocumented. The Yellow Card scheme is one of the few measurable markers for our involvement in patient care at a national level. We should view increased participation in the Yellow Card scheme as essential to our developing role.

One can only hope that Xrayser is heartened by the proposals for supplementary prescribing by pharmacists released on April 16. The proposals clearly indicate the importance of ADR reporting in future supplementary prescribing, and we would do well to start taking our responsibilities in ADR reporting seriously now.

Anthony Cox
West Midlands Centre for Adverse Drug Reaction Reporting

Advancedinfo

MAY 17-19
United Kingdom Clinical Pharmacy Association Spring Symposium, including the annual general meeting on the 18th, at the Hilton Manchester Airport Hotel. Further information from Mrs Kennedy on Tel 0116 277 6999.

MAY 20
Pharmaceutical Services Negotiating Committee national seminar on Local Pharmaceutical Service (LPS) pilots in Birmingham. Further information from Kim Bennett at the PSNC on 01296 432823.

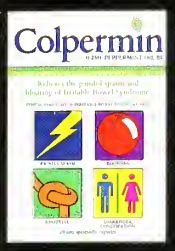
MAY 22
Royal Society of Medicine's pharmaceutical medicine and research section: *Implementation of the Diabetes NSF* at 1, Wimpole Street, London. Further information on Tel 020 7290 3935/2985.

MAY 22
Effectively implementing clinical governance in community pharmacy a medM conference in London. Further information on Tel 01908 671137 or *www.medm.co.uk*

MAY 22-24
The NHS Confederation annual conference and exhibition at the Harrogate International Centre. Further information on 01908 518243 or email *connecting2002@interchangegroup.com*

MAY 28-29
Creating a profitable future for your pharmacy a medM conference at the Winterhill Conference Centre, Milton Keynes. Further information on Tel: 01908 671137 or *www.medm.co.uk*

YOU CAN'T PREDICT WHAT IBS THROWS AT YOU



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SUPPORT FOR JOI

In the second of his articles on obesity *Omar Ali*, a pharmacist on the National Obesity Forum, looks at drug treatment

Weighing up drugs

THE COLLEGE OF PHARMACY PRACTICE

This course (module 1235), in association with multiple choice questions being published in *C&D* June 1, provides one hour's continuing education

Learning Need

- To understand how anti-obesity drugs work in weight loss
- To be aware of safety implications for orlistat and sibutramine
- To be aware of NICE's view of drug treatments for obesity
- To know how pharmacists can intervene
- To be aware of obesity assessment and treatment guidelines

Achieving weight loss is not a problem. Maintaining that weight loss safely is the challenge that has, until recently, eluded us. Historically, the use (and abuse) of centrally-acting appetite suppressants has marred the treatment of obesity.

These amphetamine-based compounds work by suppressing appetite, but their mood-altering and addictive properties are far from desirable. Phentermine and dexfenfluramine are no longer licensed because of their cardiovascular effects although, worryingly, some agencies still offer them on the internet.

The simplest agents advocated through the ages are bulk-forming agents such as methylcellulose, which swells in contact with liquid, resulting in a feeling of fullness. Although it has been proposed that patients then eat less, there is little to substantiate this. Furthermore, these agents may cause abdominal distension and internal obstruction.

Orlistat (Xenical) probably represents the first real weapon in our arsenal of therapeutic interventions. Orlistat is a hydrogenated derivative of a natural product isolated from *Streptomyces toxytricini*, and is a potent, long-acting inhibitor of pancreatic lipase, an enzyme found in the lumen of the gastrointestinal tract.

This enzyme is responsible for breaking down dietary fat into free fatty acids and diacylglycerol, which are subsequently absorbed through villi in the ileum. Covalent binding to, and subsequent inactivation of, the lipases results in inhibited absorption of up to 30 per cent of dietary fat. This fat passes through the gastrointesinal tract and appears in the stools. Weight loss results from restriction of energy-dense fat.

The National Institute of Clinical Excellence reported positive findings in its review of over 14 trials (*Health Technology Appraisal*, April 2001). Orlistat results in up to 5kg weight loss over and above placebo per year. There were also significant reductions in total cholesterol, ratio of total cholesterol to high density lipoprotein, and both systolic and diastolic blood pressures.

Side effects are mostly related to the GI tract: oily rectal spotting (27 per cent), flatus and discharge (24 per cent) and faecal urgency/oily stools (20 per cent). Theoretically, malabsorption of fat-soluble vitamins (A, D, E and K) can occur but this appears to be rare.

The ongoing XENDOS study is examining prevention of type-2 diabetes development in obese patients on orlistat and a further US study combines orlistat with insulin in overweight diabetic patients.

The launch of sibutramine (Reductil) has renewed enthusiasm in obesity management. Sibutramine acts centrally as a re-uptake inhibitor of serotonin and, to a lesser extent, noradrenaline, and is essentially an SNRI. Central sympathetic activity (via alpha-1 and beta-1 adrenoceptors) and serotonergic stimulation (at 5-

Saturn Stills/Science Photo Library

Continued on page 22 ▶

Xenical, the anti-obesity drug treatment from Roche

◀ Continued from page 21

Pharmacists have much to offer in the form of interventions before patients are diagnosed with morbidities. A simple but effective message is that waist measurement over 90–100cm for females and males and triglycerides (over two) are alarm bells for insulin resistance.

These can be measured easily. Pharmacists, as the first point of contact, can easily identify these individuals. Furthermore, within a structured flow-plan, measurement of BMI, waist size and a nominal triglyceride level would go some way to bringing targets for intervention to the attention of primary care – whether they would be welcomed by physicians is another issue.

Pharmacists can give support to patients already on weight-loss plans, particularly if on drug therapy. Primary care does not have necessary resources for monitoring these patients.

Pharmacists could undertake joint projects whereby, for instance, they could carry out blood pressure and weight monitoring and refer where appropriate.

Remember that weight maintenance may well mean stable weight. The fact that initial weight loss may plateau, and some or all the lost weight be regained, does not necessarily mean failure.

Firstly, maintaining constant weight is partial success in that the patient may have increased weight if there had been no intervention. Furthermore, if waist size has reduced but weight remained constant, this represents significant benefit both in body fat composition and health outcome risk.

The question, put explicitly by Dr Blackburn (Harvard Medical School, Boston, Massachusetts) is this: "Can we bring the obesity epidemic to an end given the natural state and the created environment?"

While there may be no empirical solution, he states emphatically: "We believe there is only one practical answer at this moment.

"We must engage in very intensive, structured follow-up interventions with all our patients."

HT2A and 2C receptors) gives a dual mechanism of action. Firstly satiety enhancement leads to the sensation of having eaten enough, with reports of 20 per cent reduction in food intake. Secondly, sympathetically mediated thermogenesis results in an elevated BMR (basal metabolic rate). This remains elevated even when weight loss occurs. Usually BMR comes down as weight is lost, thus making it harder to bring about further weight loss. Hence the elevated BMR effectively burns calories by increasing baseline energy expenditure and so gives an energy balance more conducive to weight loss.

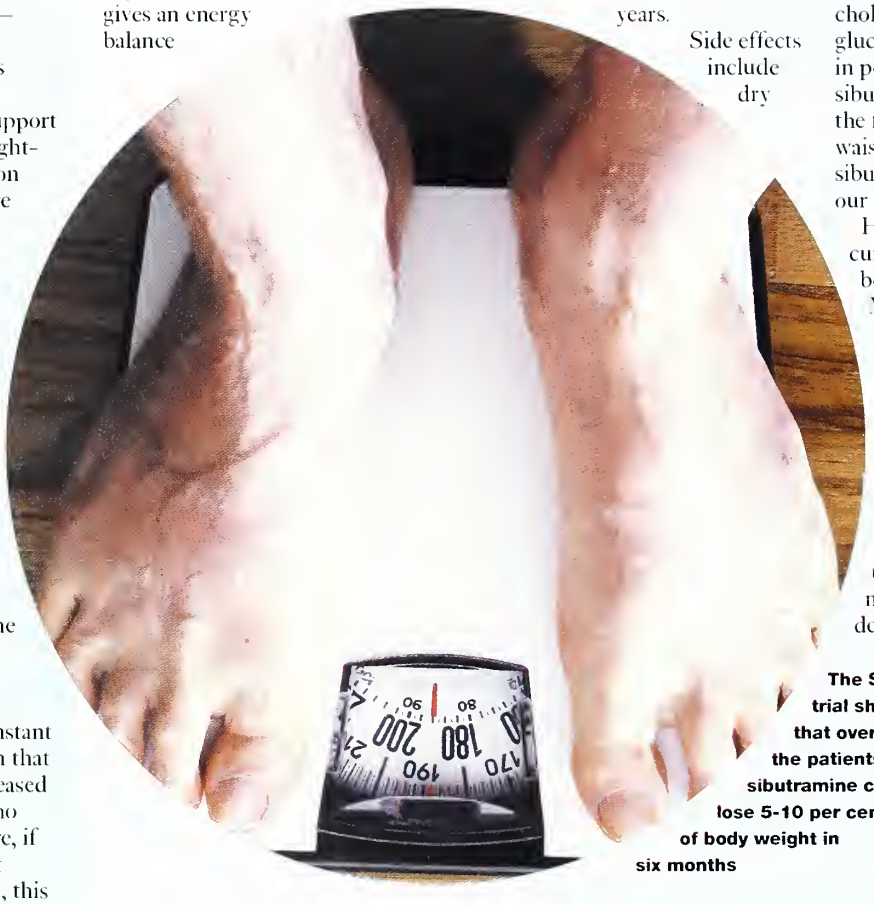
NICE recently put sibutramine under its spotlight (*Health Technology Appraisal 31*, October 2001). A review of 16 trials found it produced dose-dependent weight loss in over 5,000 patients. Mean weight loss over and above placebo was up to 5kg after one year. People who had lost weight on sibutramine were more likely to maintain the loss if the treatment was extended than those who were randomised to a diet and exercise programme.

The STORM trial revealed that over half the patients on sibutramine can lose 5-10 per cent of body weight in six months, which is sustained for two years.

Side effects include dry mouth, insomnia, constipation and loss of appetite (the latter possibly being seen as favourable). Sibutramine can increase blood pressure, so blood pressure monitoring is recommended and the drug should not be used if blood pressure is higher than 145/90mmHg, or in those who experience over a 10mmHg rise (systolic or diastolic) while on therapy. Patients who lose weight on sibutramine show reduced blood pressure, which is not surprising as weight loss is associated with blood pressure reduction. It is those who do not respond who tend to show an unwanted rise in BP.

Significant reductions in total cholesterol, triglycerides and glucose parameters have been seen in people with diabetes who take sibutramine. This, together with the favourable effects on waist and waist to hip ratio, puts sibutramine in a positive light in our fight against obesity.

However, sibutramine is currently the subject of a risk-benefit review by the European Medicines Evaluation Agency, following four deaths associated with the drug in the UK and Italy. In March, the Medicines Control Agency advised that patients taking the drug should continue, but report to their GP if they felt unwell. The UK fatalities both had underlying conditions that might have contributed to their deaths, said the MCA.



The STORM trial showed that over half the patients on sibutramine could lose 5-10 per cent of body weight in six months

For both orlistat and sibutramine, NICE has defined criteria for drug entitlement, continuation policy, and when to withdraw therapy.

Neither drug should be used as a stand-alone answer to obesity management. NICE clearly states that these drugs should be used only as part of an overall treatment programme for nutritional obesity. Hence advice on diet, physical activity and behaviour strategies is implicit.

Although both agents may be prescribed for people with a BMI of 30kg/m^2 or more, sibutramine can be prescribed when co-morbidities exist in patients with a BMI of 27, whereas for orlistat this is a BMI of 28.

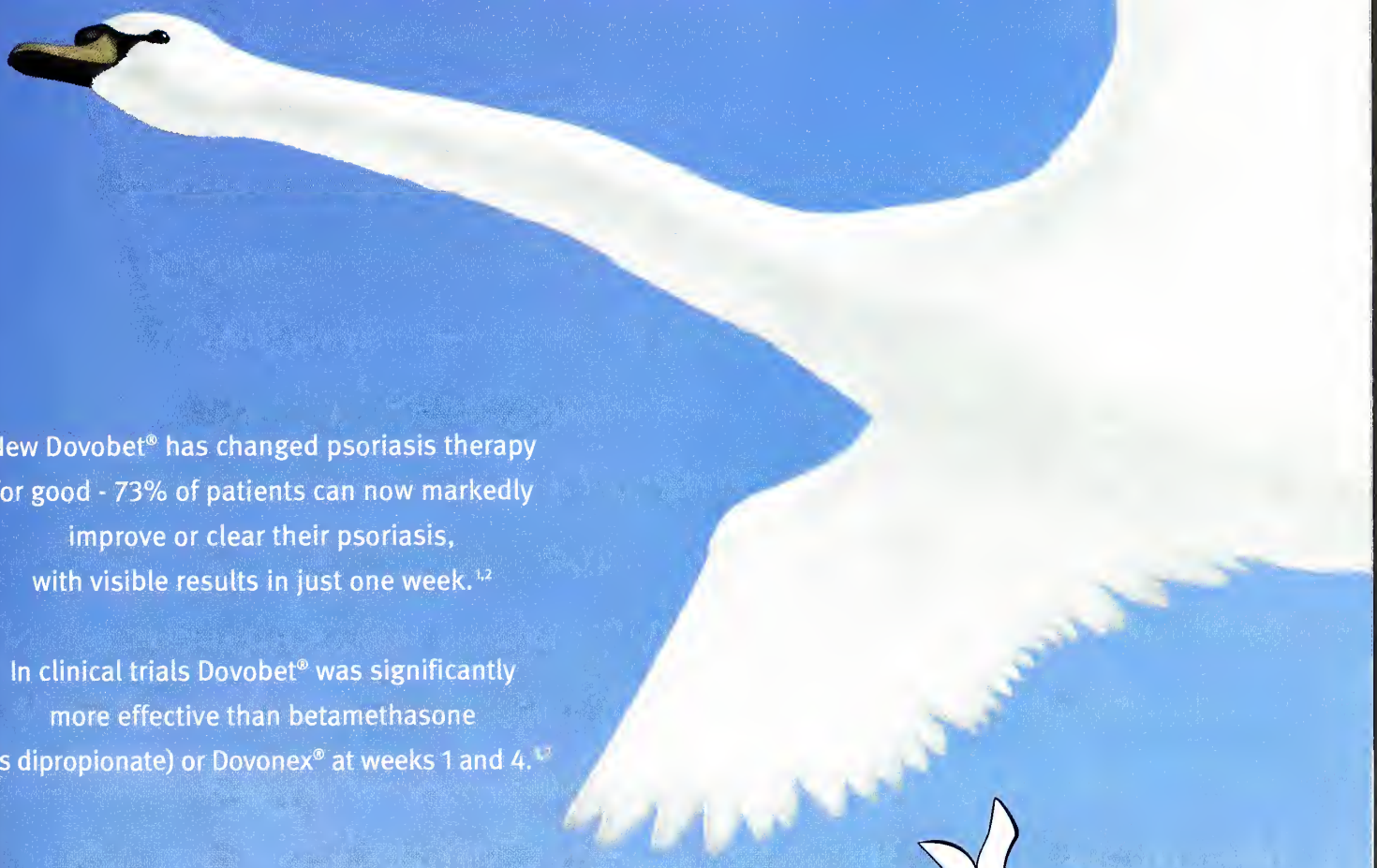
Licensing for orlistat states that patients should have lost at least 2.5kg by dietary control and physical activity alone in the preceding month. Conversely, sibutramine's licence states that the drug should be used only where this type of weight reduction has been attempted but not achieved.

Once on orlistat or sibutramine, evidence of 5 per cent and 10 per cent weight loss at three and six months, respectively, is required to continue treatment.

NICE says that treatment should be withdrawn if there is an inadequate response Here lies a paradox – if significant weight loss is not achieved at three and six months, then guidance is to stop therapy. The analogy is one where, if antihypertensive therapy is not working, then stop drug treatment and leave individuals to their own devices.

Continued on page 24 ▶

REMARKABLY FAST AND POWERFUL IN PSORIASIS



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calcipotriol / betamethasone dipropionate

New Dovobet® - Fast, effective, first-line therapy in psoriasis.

Abbreviated Prescribing Information for Dovobet® 50 microgram/g + 0.5 mg/g Ointment. **Indications:** Treatment of stable plaque psoriasis vulgaris amenable to topical therapy. **Active Ingredients:** 50 µg/g calcipotriol (as hydrate) and 500 µg/g betamethasone (as dipropionate). **Dosage and Administration:** Apply twice daily not exceeding 4 weeks. Maximum dose should not exceed 15g/day. Maximum dose should not exceed 100g/week. Treated area should not be more than 30% of body surface. No experience of use for longer than 4 weeks or of repeated use. No recommendation for use in people under 18 years. **Contra-indications:** Hypersensitivity to any constituents. Patients with known calcium metabolism disorders. Viral skin lesions, fungal or bacterial skin infections, parasitic infections, skin manifestations in relation to tuberculosis or syphilis, rosacea, perioral dermatitis, acne vulgaris, atrophic skin, striae atrophicae, fragility of skin veins, ichthyosis, acne rosacea, ulcera, wounds, perianal and genital pruritus. Guttate, erythrodermic, exfoliative, pustular psoriasis. Severe renal insufficiency or severe hepatic disorders. **Precautions and Warnings:** Avoid inadvertent transfer to scalp, face, mouth and eyes. Wash hands after applying. Avoid concurrent treatment with other steroids. Adrenocortical suppression or impact on the metabolic control of diabetes mellitus may occur. Avoid application on large areas of damaged skin, under occlusive dressings or on mucous membranes or skin folds. There may be a risk of generalised pustular psoriasis. No experience of use on scalp. No experience of concurrent use with other antipsoriatic products or phototherapy. **Use in Pregnancy and Lactation:** Only use in pregnancy when potential benefit justifies potential risks. Caution when prescribed for women who breast feed. Instruct patient not to use on breast when breast-feeding. **Side Effects:** Pruritus, rash, folliculitis. Undesirable effects observed for calcipotriol and betamethasone. Calcipotriol: transient local irritation, dermatitis, pruritus, erythema, aggravation of psoriasis, photosensitivity, hypersensitivity reactions including very rare cases of angioedema and facial oedema. Hypercalcaemia or hypercalciuria may appear very rarely. Betamethasone: local reactions, especially during prolonged application including skin atrophy, telangiectasia, striae, folliculitis, hypertrichosis, perioral dermatitis, allergic contact dermatitis, depigmentation, increase of intraocular pressure, cataract, colloid milia, generalised pustular psoriasis. Systemic effects occur more frequently when applied under occlusion, to large areas and long term treatment. **Legal Category:** POM. **Product Licence Number and Holder:** 05293/0003. LEO Pharmaceutical Products, Ballerup, Denmark. **Basic NHS Price:** £55.00/120g. **Date of Preparation:** May 2002. **References:** 1. Douglas WS et al. Poster presented at the EADV 20th, Munich, Germany. 2. Data on file, LEO Pharmaceutical

Full information is available from:
LEO Pharmaceuticals, Longwick Road,
Princes Risborough,
Buckinghamshire, HP27 9RR.
® Registered Trademark
e-mail: Dovobet.Enquiries@[illegible].com

Continued from page 22

Table 3: Obesity Assessment & Treatment Guidelines from NIH

1. Assessment	Measure weight, height and determine BMI
	Measure waist circumference
	Assess co-morbidities
	Assess need for treatment
	Assess readiness for treatment
2. Management	
Set realistic goals	Initial weight loss – 10 per cent body weight over six months Rate of weight loss – 1-2lb (0.5-1kg) per week
Diet	Energy intake deficit: 500-1000 kcal/day Total energy intake NEVER below 800kcal Consider meal replacement(s)
Physical Activity	Gradually work toward >30mins moderate-intensity physical activity on most and preferably all, days of the week
Behaviour	Self-monitoring, record keeping, stress management, stimulus control, contingency management and social support
3. Therapeutic Intervention	
Pharmacotherapy	Sibutramine and orlistat – see NICE Guidance
Bariatric surgery	Offered to patients who are morbidly obese
4. Ongoing Assessment	
	Regular follow-up cycle and monitoring

Adapted from the National Institute of Health, Melanson KJ et al. Cardiol Rev. 2001

Actionplan

Obesity Part 2

1. Do you know any sources of amphetamine-type drugs on the internet? Are they available in this country? If so, what will you do about it?
2. Check your PMRs. How many patients have been prescribed orlistat? How many are still taking it? Is the drop-out rate high? If so, why? Is it because of side effects or the patient not losing weight or maintaining the weight lost?
3. Using various information sources find out all you can about sibutramine, with particular reference to its toxicity. Review these findings. What would you do about a new prescription for this drug? Talk to the prescriber? Discuss it with the patient?
4. In your practice workbook, discuss the main side actions and cautions of the two drugs used to control weight. If a patient asks for your advice about using either of these drugs, what would you answer in view of the above?

Distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, *C&D*'s readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the June 1 issue, which will cover this week's CPP-accredited modules, together with those in the May 4 and May 25 issues.

These will cover:

● **Obesity Part 1 (1234)** ● **Obesity Part 2 (1235)** ● **MI (1236).**

A telephone marking service offers independent verification of results – details on the monthly MCQ papers. People wanting to register for Pharmacy Update can contact Mary Prebble on 01732 377269.

Medicalmatters

Chicken pox vaccine may lead to shingles epidemic

Vaccinations to prevent children catching chicken pox may lead to an epidemic of shingles in the older population, according to researchers.

Adult exposure to children with chicken pox helps to protect against shingles, which flares up when there is a fall in immunity. Only people who have been infected with the chicken pox virus get shingles when the dormant virus is re-activated.

Contact with chicken pox is estimated to boost cell-mediated immunity to the virus for up to 20 years, according to the paper in *Vaccine*.

Researchers claim a mass vaccination campaign against chicken pox would produce a substantial increase in shingle cases in the first 30 -50 years following the campaign before decreasing again.

Eliminating chicken pox in a population the size of the USA (280 million) would prevent 5,000 deaths from chicken pox but lea to a similar number of deaths from shingles.

GlaxoSmithKline submitted application earlier this year for vaccine combining chicken pox with the triple measles, mumps and rubella.

A spokesman for the Public Health Laboratory Service sai that they were carrying out research to assess the impact of vaccination against chicken po the UK.

Hell to heaven in minutes for hayfever eyes

*One drop of Zaditen gives superior efficacy**
compared to a 2-week course of sodium cromoglycate[1]

new ZADITEN®▼
ketotifen fumarate eye drops, 0.025%

www.hayfevereyes.com

TEN® Eye Drops (ketotifen) UK and Irish ABBREVIATED CRIBING INFORMATION
ations: Symptomatic treatment of seasonal allergic conjunctivitis. **ntotians: Eye drops salution:** 1ml contains 0.345mg ketotifen gen fumorate (= 0.25mg ketotifen). Each drop contains 8.5 microgram en hydrogen fumarate. **Dosage and Administratian: Adults, ly and adalescents (12 years and aver):** One drop into nctival sac twice a day. **Children (under 12):** Efficacy data concerning children below 12 years af age is not available. Limited safety data is ble in children from the age of 3 years. **Cantraindicatians:** sensitivity to ketotifen or excipients. **Precautions: Eye drops ulation:** Do not apply whilst wearing soft contact lenses. Remove lenses before administration and do not reinsert for at least 15 minutes. May discolour soft lenses. **Interactions:** Other eye medications: Leave at least 5 minutes between administration of medications. CNS depressants, antihistamines, alcohol. **Pregnancy and lactation: Pregnancy:** Caution. No data in humans. Increased pre and post natal mortality in animal studies, but no teratogenicity. **Lactatian:** Topical application unlikely to produce detectable quantities in breast milk, so can be used during lactation. **Effects an ability ta drive or operate machinery:** May cause blurred vision or somnolence. Do not drive or operate machinery if this occurs. **Side-Effects: Ocular: Between 1% and 2%:** burning/stinging, punctate corneal epithelial erosion. **<1%:** blurring of vision, dry eyes, eyelid disorder, conjunctivitis, eye pain, photophobia, subconjunctival haemorrhage. **Systemic: <1%:** headache, somnolence, skin rash, eczema, urticaria, dry mouth, allergic reaction. **Package Quantities, Product Licence Numbers and price: UK:** 1 x 5ml bottle, PL 00101/0614, £9.75 (Basic NHS price). **Ireland:** 1 x 5ml bottle, PA 914/3/1. **Legal Categary:** POM. **Date of last revision:** March 8th 2002.

Reference:
1. Greiner JV. Data on file.

***Effect on itching**

)/02/02 Novartis Ophthalmics (UK) Limited, Delta House, Southwood Crescent, Southwood, Farnborough, Hants GU14 0NL. March 2002

NOVARTIS OPHTHALMICS

CHD not prevented by HRT

Hormone replacement therapy has not been proven to be beneficial in preventing coronary heart disease, according to the Committee on Safety of Medicines and the Medicines Control Agency.

The initiation and continuation of HRT should be based on established indications such as menopausal symptoms and prevention of osteoporosis, the CSM and MCA say in the April issue of *Current Problems in Pharmacovigilance*.

Product information for health professionals and patients is being updated to ensure consistency within the European Union.

Prescribers of HRT should take the following factors into consideration:

- the benefits of HRT outweigh the risks, but care in prescribing must be taken with long-term (over 5 years) use.
- recent trials show a slight tendency of HRT to cause increased rates of CHD in the first year or two of treatment, with a possible decrease in later years, both in women with previous CHD and in those without. Consideration should be given to stopping HRT after any cardiovascular disease event.
- there is an increased risk of venous thromboembolism in women taking HRT. This risk is higher in older women.
- the risk of breast cancer applies to combined oestrogen and progestogen therapy as well as to oestrogen only therapy. The addition of progestogen does not confer protection against the increased risk of developing breast cancer, and might increase that risk
- long term use of combined HRT is linked to an increase in risk of endometrial cancer. The increased risk becomes clinically significant after five years of treatment.

For more information:

www.mca.gov.uk

GPs fail to follow NICE guidance

Rheumatoid arthritis (RA) and osteoarthritis (OA) patients remain at risk from their treatment because doctors are not following guidance issued by the National Institute for Clinical Excellence last year, claims the UK's leading arthritis support group.

Some 77 per cent of GPs surveyed by Arthritis Care were aware of NICE's guidance on the use of COX-2 selective inhibitors for RA and OA. Yet only 11 per cent of those GPs claimed they had significantly increased their prescription of these drugs to appropriate patients.

The NICE guidance states that COX-2s should be used in preference to traditional NSAIDs only in patients with OA and RA who may be at high risk of developing serious gastrointestinal adverse effects.

Of the 196 GPs questioned, only 30 per cent selected a COX-2 selective inhibitor for the treatment of an OA patient aged 67 years; 31 per cent for an OA patient with diabetes; 39 per cent for an OA patient with a history of peptic ulcers; and 21 per cent for a RA patient receiving 150mg diclofenac for the past two years.

"According to the NICE guidance, all of these patients would be considered at high risk of developing serious gastrointestinal side effects and, therefore, may be suitable for receiving a COX-2 selective inhibitor," says the support group.

NICE recommends infliximab for Crohn's disease

The National Institute for Clinical Excellence is recommending that infliximab should be available for people with severe Crohn's disease who meet specific criteria.

The following conditions must all be met before initiating treatment:

- the patient must have severe Crohn's disease, characterised by poor general health, weight loss, severe abdominal pain and frequent diarrhoea.
- patients whose condition has not responded to treatment with immunomodulating drugs and corticosteroids, or who have been intolerant of, or experienced toxicity from these treatments
- patients for whom surgery is inappropriate.

Out of 31,000 Crohn's sufferers in England and 1,800 in Wales, only about 1,000 patients will be eligible for treatment, says NICE.

The cost of treatment is estimated at £2.5 million for the first year. In subsequent years the cost will be less, as the drug will only be offered to patients who have previously responded to infliximab or for new patients.

Infliximab targets tumour necrosis factor, a protein believed to be partly responsible for causing the inflammation of the intestine in Crohn's sufferers.

For more information:

www.nice.org.uk

Stay one step ahead in athlete's foot.

Unlike other athlete's foot treatments only Lamisil®AT Cream provides up to three months protection - after just one week

And only Lamisil®AT Cream is fungicidal right from the minute it's applied

So for effective, long lasting relief make sure your customers don't step out with anything less than Lamisil®AT

Terbinafine Hydrochloride

LAMISIL®AT CREAM - FUNGICIDAL RIGHT FROM THE START

Prescribing information: LAMISIL®AT **Presentation:** Cream containing terbinafine hydrochloride 1.0 % ww. **Indications:** For the treatment of athlete's foot and dhobie itch. **Dosage and administration:** The cream is applied once or twice daily. The duration of treatment is one week for tinea pedis and one to two weeks for tinea cruris. Not recommended for children under 16. **Contraindications:** Hypersensitivity to terbinafine or any of the excipients. **Precautions:** For external use, avoid contact with the eyes. **Pregnancy and lactation:** Not recommended during pregnancy or lactation. **Side effects:** Redness and irritation at the site of application. Discontinue treatment in an allergic reaction occurs. Legal category: P **Retail Price:** £4.99 (7.5g tube) **Product licence number:** PL0030/0144 **Product licence holder:**

Novartis Consumer Health, Wimblehurst Road, Horsham, Sussex RH12 5AB.

Customer Careline 01403 218111 Fax 01403 323 919 Email customer.care@ch.novartis.com

07/2004/1442

Marketwatch

Scriptlines

Anti-rejection drug in a tablet

Wyeth has launched a tablet form of the immunosuppressant, Rapamune (sirolimus).

Previously it was only available as an oral liquid. The 1mg tablets are used for the prophylaxis of organ rejection in adults at low to moderate immunological risk receiving a renal transplant.

It is recommended that Rapamune be used initially in combination with cyclosporin and corticosteroids for two to three months.

After this period Rapamune may be continued as maintenance therapy with corticosteroids, while cyclosporin is gradually stopped.

Price: £90 (30s), £300 (100s)

Pack size: 30 & 100 tablets
Pip code: 287-4675 (30), 287-4683 (100)
Wyeth
Tel: 01628 604377

Britannia replaces pen

Britannia Pharmaceuticals is to replace its Britaject Pen (apomorphine 10mg per ml) with an updated version called APO-go Pen.

APO-go will be phased in during May as stocks of Britaject are exhausted. Both contain the same drug in the same strength.

The design of the pen has been improved to minimise the risk of accidentally pulling out the plunger too far and making the pen inoperable. Patients can transfer from the Britaject Pen to the APO-go Pen without changing dose. Needles are available free from Britannia.

Price £123.91 (ZD)

Pack size: five pens
Pip code: 287-4717
Britannia Pharmaceuticals
Tel: 01737 773741

Frontshop

Liquid assets for K-Y lubricant

Johnson & Johnson is launching K-Y Liquid personal lubricant in the UK. K-Y Liquid is already established in the US where it was introduced five years ago and now has a 7.1 per cent share of the total lubricant market. Liquid lubricants are the fastest growing segment of the US market.

Containing glycerine, the water-based lubricant is non-sticky and will not dry out. The product is odourless, clean rinsing and safe to use with condoms.

● K-Y Jelly has been repackaged in a more aesthetically appealing tube with a less medicinal look. The formulation remains unchanged.

Price: £4.99

Pack size: 70ml
Pip code : 284-9628
Johnson & Johnson Ltd
Tel: 01628 822222

Angela helps raise leg health awareness

Boehringer Ingelheim has produced an informative booklet as part of an educational campaign to support its Antistax leg vein supplement.

Entitled *The Leg Health Charter*, it is introduced by Angela Rippon, the former BBC newsreader renowned for her lovely legs.

The booklet contains exercises, nutrition and beauty tips to help women keep their legs in shape, as well as advice on the causes, symptoms and management of poor leg circulation.

Pharmacies can obtain supplies of free copies of the booklet for customers.

For more information :

Boehringer Ingelheim
Tel: 01344 741493

Carnation hits the bullseye

Cuxson Gerrard is supporting Carnation Corn Caps with a £250,000 advertising campaign targeting corn sufferers during the peak summer footcare season.

The advertising uses the imagery of a target superimposed over a foot.

A red bullseye highlights the corn to reinforce the message 'on target to remove corns fast'.

The campaign will appear in national newspapers and women's and lifestyle magazines throughout the summer months.

A range of display options is available to pharmacies.

For more information :

Cuxson Gerrard & Co Ltd
Tel: 0121 544 7117

Natural way to treat head lice

Natural Science is relaunching Nice 'n Clear head lice treatment with an improved formulation and new packaging.

Nice 'n Clear contains neem oil, a natural vegetable oil derived from the seeds of the neem tree.

The lotion is claimed to alter the louse's breeding capacity, making it incapable of laying eggs. The product is formulated as a leave-in conditioner. Used twice weekly, it may help act as a repellent when rubbed into dry hair.

It is dermatologically tested and can be used safely by asthmatics, epileptics, pregnant mums and those with sensitive skins.

Price: £7.99

Pack size: 200ml Pip code: 267-2988
Distributors: Chemist Brokers
Tel: 023 9222 2500

Lights. Kodak. Action!

Kodak continues its leading role in the Single Use Camera and APS markets with a huge £5 million spend on TV and press this summer, together with exciting new models.

New *Ultra* Compact Flash Single Use Camera

New Single-Use cameras include the *Kodak Ultra* Compact Day at £5.99 RRP and the *Kodak Ultra* Compact Flash at £8.99 RRP. The redesigned *Kodak Ultra* Sport is down to £9.99 RRP for even greater value.

New in the *Advantix* camera range, there's the *Advantix* C470 and the *Advantix* F620. There are 6 models to choose from including the No. 1 selling *Advantix* F350 camera. Prices start from as little as £29.99 RRP for the *Advantix* F320 camera, up to £99.99 RRP for the *Advantix* T700 Zoom camera.

Advantix T700 Zoom camera

Kodak cameras are best sellers in these markets, and with this investment for 2002, make sure you're in on the action. Stock up and display to help drive sales through your store.

To place an order, contact your Kodak Sales Development Manager or call Debbie on 01442 844196. For Swains serviced customers call 01485 536200.

In the Republic of Ireland contact Speko Customer Services on 1850 776563 (call Save).

From Northern Ireland Freephone 0800 3899 246.

For more information contact your Chemist Brokers representative or John Sumpner on 02392 222500.

Share Moments. Share Life.™

www.kodak.co.uk

Scriptlines

Cancer pain relief from Napp

Napp has launched a transdermal patch containing buprenorphine.

Transtec is licensed for moderate to severe cancer pain and severe pain that does not respond to non-opioid analgesics. It is available in three strengths, which release 35, 52.5 or 70mcg of buprenorphine per hour over a 72-hour period.

Patients requiring a supplementary analgesic for breakthrough pain may take buprenorphine sublingual tablets in addition to the patch.

Transtec, a Schedule 3 controlled drug, is contraindicated in patients who are receiving MAOI or have taken them within the last two weeks, and in patients suffering from myasthenia gravis or delirium tremens.

Price: 35mcg £28.97, 52.5mcg £43.46, 70mcg £57.94

Pack size: five patches per pack
Pip code: see April 27 *Price List Supplement*
Napp Pharmaceuticals
Tel: 01223 424444

Osteoarthritis relief for the knee

A treatment for the pain caused by knee osteoarthritis has been added to the May issue of the *Drug Tariff*.

Arthrease (sodium hyaluronate) injection from DePuy, aids joint lubrication, allows for greater mobility and reduces joint pain.

Price: £200

Pack size: three injections
Pip code: 286-9212
DePuy International
Tel: 0113 2700461

Frontshop

Lynx goes soft on men with skincare duo

Lever Fabergé is adding two post-shave skincare products to the Lynx range this month.

Lynx Post Shave Moisturiser and Post Shave Soothing Gel are targeted at new users in the growing men's skincare market.

The moisturiser is designed for men who suffer from dry skin while the gel is suitable for those who suffer from soreness and redness which is caused by razor burn. Both products have been dermatologically tested.

● The men's skincare market h grown in value by 28 per cent to £18.4 million in the past year.

Price: £3.99

Pip code: Moisturiser 286-1409, Gel 286-1417
Lever Fabergé
Tel: 020 8439 6100

Well, I never ...

Accantia Health & Beauty is supporting Lil-lets tampons with a £1.5 million national TV and press advertising campaign from May until July.

The TV commercial is based on a fictitious 1970s TV show called *Well I never!*

Sandy and Mervin, the show's hosts, look at innovations and how they work. Sandy tells Mervin that Lil-lets tampons are 30 per cent more effective than other tampons at preventing leaks.

She demonstrates this through simple experiment where a Lil-lets tampon and another tampon are placed into glass tubes and left to expand.

For more information :

Accantia Health & Beauty Ltd
Tel: 0121 327 4750

Polaroid puts you in the picture

Polaroid is introducing an instant photography camera package suitable for pharmacies to set up an instant document photography business.

The Polaroid M403R is an attractively designed and lighter successor to the Miniportrait 403 camera.

Design improvements include a new electronic shutter for improved image contrast. The LCD control panel on the side of the casing allows the user to easily select the preferred photo format.

The on-off button is now sited on the camera handle and there is an auto power-off function that automatically shuts the power down after two minutes of inactivity.

The camera comes in a kit including passport picture cutter and retractable white backdrop plus eye-catching point of sale material.

For a limited period, Polaroid is offering the camera at £699 plus VAT (a saving of £100 on the normal price) plus 300 sheets of free passport film.

Polaroid provides free training and installation.

For more information:
Polaroid UK Ltd
Tel: 01582 632290

TV next week

Anadin: All areas
Beconase: U
Benadryl Allergy Relief: B, G, Y, A, HTV, W, M, LWT, TT
Bodyform Micro: All areas
Calpol Fast Melts: All areas except U
Clearblue Pregnancy Test Kit: All areas + C5 except GTV, U, CTV, C4
Eumovate: All areas except U, CTV
Feminax: GTV, B, G, Y, C4, C5
Imodium: All areas
Lil-lets: All areas except GTV, C, CTV, GMTV
Lucozade Sport: All areas except U, CTV
Macleans Whitening: All areas except U, CTV
Movelat Relief: C5
Oxy: Sat
Panadol: All areas except U, CTV
Poligrip: All areas except U, CTV
Ribena: All areas except U, CTV
Seven Seas Neutra Taste: Y
Wella Vivality: All areas except GTV, B,Y, A, CTV, TT
Zovirax: U

PharmaSite for next week: Piriton – Window, **Beconase** – In-store, **Canesten Once** – Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Soap: the saga continues

As part of a series of product category reviews, Information Resources analyses the personal hygiene market in pharmacies

As the pace of life increases, it seems that where personal hygiene is concerned the quicker we can get clean the better. The long-term trend in favour of showering instead of a leisurely bath appears set to continue.

The personal hygiene market, which includes personal wash, deodorants and body sprays, is worth £848 million. The market is fairly flat overall with total sales growing by 1.3 per cent although the pharmacy market has declined by 5.4 per cent to £49m (y/e 24 March 2002).

Most sectors within personal hygiene through pharmacies are in decline except bath salts where sales rose by 7.5 per cent. This reverses the trend through all outlets where sales have declined by 3.9 per cent.

The leading bath salts brand is Radox with sales increasing by 4.2 per cent. The largest sector within personal wash is still bath liquids. Sales have declined by 3.8 per cent to £8m, with Radox keeping the top spot.

Johnson's Baby Bath liquid range is ranked second. The fastest growing brand within the top 10 is the Imperial Leather range with sales up by 24.6 per cent.

Sales of shower products are fairly static through pharmacies, declining by 0.8 per cent to £6m. Radox is the leading brand, with Imperial Leather ranked second. Palmolive is ranked third with sales increasing by 32.7 per cent, with growth being fuelled by Palmolive Vitamins and Palmolive Active.

There has been plenty of innovation, with the launch of products such as Imperial Leather Foamburst.

Bar soaps are declining overall and through pharmacies by 7.4 per cent to £8m. The leading brand is Yardley with Dove ranked second. Liquid soaps also declined through pharmacies by 8.5 per cent to £2m although overall sales are up by 10.7 per cent.

The long-term trend is for liquid soaps to grow at the expense of the bar soaps. The recently launched Imperial Leather Foamburst liquid soap is an example of new product development in this area by manufacturers.

The body wash sector has declined by 19 per cent to £1m. It is an area that has previously seen a lot of new product development but with innovation spreading to shower products there has been a blurring of the two sectors.

As body washes are often more expensive than the new shower products, this could also explain its decline. Oil of Olay is the leading brand, with Dove currently second with sales increasing by 15.7 per cent.

While the sector in general is in decline, a number of brands in the top 10 are showing year on year growth. The fastest growing brand is Simple, with sales increasing by 16.2 per cent.

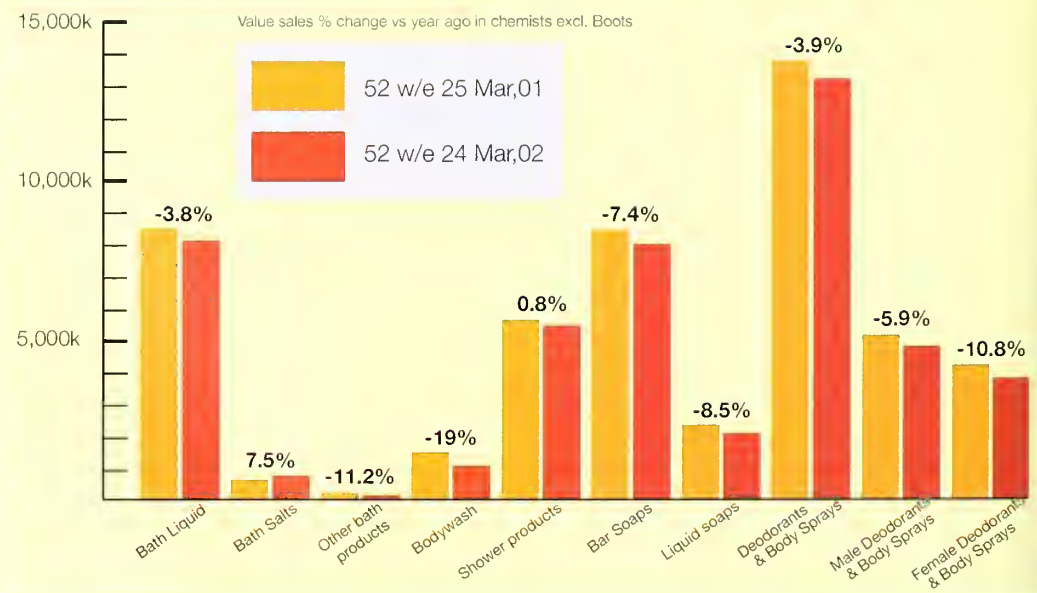
The deodorants and body sprays sector is declining through pharmacies, with sales down by 5.6 per cent to £22m. The sector is split between deodorants and mal and female body sprays.

Although deodorants account for over half the sales within this sector, the leading brand is still Lynx body spray. Sure deodorant is ranked second followed by Impulse body sprays. Arrid deodorant is the fastest growing brand in the top 10 with sales increasing by 26 per cent.

Top pharmacy brands

1. Lynx body sprays
2. Sure deodorants
3. Radox bath liquid
4. Impulse body sprays
5. Dove deodorants
6. Right Guard deodorants
7. Radox shower products
8. Imperial Leather shower products
9. Johnsons baby bath liquid
10. Yardley bar soaps

Personal Hygiene Products



information resources

David Evans, pharmacy director of East Midlands-based Manor Pharmacy

"The personal hygiene business is currently fairly buoyant in pharmacy despite increasing competition from supermarkets and budget toiletry outlets.

Sales of traditional bars of soap have declined drastically, while there is increased demand for liquid soaps and shower gels.

Sales of traditional bath products, such as bath salts and gels, have decreased. However, there is still a market for bath additives, particularly aromatherapy style products.

Deodorant sales have changed significantly and Impulse body spray is no longer the mainstay of this sector.

Sales of Pharmacy only products like Driclor and Anhydrol Forte account for less than 1 per cent of total deodorant sales.

Deodorant wipes, launched last year, have failed to make much impact on the market, accounting for less than 2 per cent of sales.

There has been some interest in "natural" deodorants, usually coinciding with media scaremongering regarding hypothetical links between aluminium in antiperspirants and Alzheimer's and breast cancer.

Special promotions with personal freshness products have been tried repeatedly but the results have been disappointing.

Looking to the future, pharmacies may struggle to retai market share and cannot compet with the convenience of buying these products in the supermarket. In addition, most pharmacies cannot compete wit the retail prices from budget toiletry retailers.

However, personal hygiene products are still perceived to b 'traditional' pharmacy lines and many customers will always expect to see such products on the shelves."

Call the professionals

Moss Pharmacy's Tricia Kennerley gives a flavour of the everyday issues that face a pharmacy superintendent working alongside the modern NHS

Do NHS managers have any idea how much resource community pharmacy has deployed in the past few years to develop the primary care agenda? Probably not. But Tricia Kennerley, appointed superintendent pharmacist for Moss Pharmacy in January, is happy to spell it out.

"We have developed a professional team which can work out in the field. Moss has five service managers and six service pharmacists in post," she says. Area managers are seeing their operational focus shift to tie in with professional developments as well.

"We have seven branches involved in the PSNC medicines management pilot; 26 branches involved in phase one of the National Prescribing Centre project, and 33 in phase two," she explains.

Moss's growth from 400 branches in 1995 to over 700 today has meant a step change in head office functions. In January 2000 the pharmacy superintendent's office gained clinical governance and professional services posts and, that April, a manager for the superintendent's office was recruited.

All this investment in professional infrastructure has, says Ms Kennerley, huge cost implications, and it is all being paid for by the company. Any suggestion that the NHS might have made some contribution raises a wry smile: "You do get some funding for local initiatives, but currently the rest has to be funded centrally."

This state of affairs was explained to the Office of Fair Trading towards the end of February when she gave evidence to its inquiry into the merits or otherwise of contract limitation. "One message I wanted to get across was that we have ploughed huge amounts into community pharmacy to deliver Government policy," she says.

She feels encouraged by her meeting. "We had an open discussion. I came away feeling positive and that they had listened to us. The OFT said if it finds after the inquiry that pharmacy services can be delivered to patients at a point of their choosing, it would not be nervous about a recommendation to maintain the status quo."

That said, she is betting the OFT will recommend some minor modifications to the relocation rules.

Moss launched a CPD portfolio for all its pharmacist staff in March. In what is likely to become increasingly common practice, their progress will be monitored through a central database. It is, says Ms Kennerley, the first time that Moss has put real money behind pharmacy training, rather than just management training.

"We are going to fund the full 30 hours CPD for our pharmacists, however they choose to do it. We will be organising workshop study days for staff. We are also trying to incorporate peer review into our quarterly management meetings." To underline the commitment, she says Moss will fund any CPD pharmacists do themselves. Management development will also be incorporated into CPD programmes.

Tricia Kennerley gets to work with her team

She hopes the CPD database will allow the company to match skills to the needs of primary care organisations as they move more into local service provision.

She says the CPD programme effectively kicked off last year when head office pharmacists were called in to plug staffing gaps. The groundwork, however, had been done earlier. She is proud of the result. "We had an in-house training day to bring them up to speed. Sixty people were involved – area managers and upwards – and they provided 800 days of locum cover in 2001."

Like other large multiples, Moss is exploring a bigger role in the dispensing process for technicians. Two technicians will start the checking course in Edinburgh in September. One works in the Prison Service pharmacy operation which Moss has a contract for in Scotland.

So how does she feel about technician checking? Cautious is the answer. "I will let them do it provided the correct procedures are in place," she says. "We are currently working on SOPs for dispensary procedures."

"We are working on SOPs for dispensary procedures"

Moss has recently rolled out Branchworld, a company intranet. This will allow branches to access "approved sites" on the internet (such as *C&D*'s website, *dotPharmacy.com*, and *Pharmology.com*).

"We will use Branchworld to deliver SOPs. They can be amended at branch level with area manager approval, depending on staffing levels and other local circumstances. We are also refining dispensing audit procedures such as the management of error reporting. Branches that tend to attract attention are those with zero reporting. We are, like many others, attempting to cultivate a 'no blame' culture to encourage reporting of near misses."

Moss is the only large multiple to have successfully bid for money from the Scottish Primary Care Modernisation Fund. The grant is going to the Moss branch in Albert Street, Dundee.

Career profile

Tricia Kennerley studied pharmacy at Bath. Her pre-reg year split between industry and hospital, working for Eli Lilly and at Charing Cross Hospital. "Industry didn't really grab me so, on qualifying (in August 1987), I went to work in St Mary's, Paddington. From there I moved to a small independent in Ascot, and then another in Hook, where I stayed for six and a half years." She started working in Hook at the same time as the business was acquired by a new owner. It was very run down and she put in a lot of work. The proprietor had a short-line wholesale business which he ran out of the shop. The pharmacy was also a pilot site for Mediphase. The experiences gained provided the springboard for her next job.

The move to Moss took place in 1995, where she was initially responsible for supplier relationships – "dealing with brand equalisation deals and with responsibility for Mediphase and things like that". In September 2000 she became NHS services director, and took on responsibility for professional services. This "tied in quite nicely" with the publication of *Pharmacy in the Future*. The past 18 months have been spent focusing on professional developments.

Is ETP going anywhere?

More than a year has passed since Lord Hunt announced which consortia were to run the ETP pilots. They are only now beginning to transmit actual prescription data. Will a national system be ready for 2004? Nina Keller-Henman finds out

"The revolution or evolution is underway," says Douglas Ball, th Prescription Pricing Authority's director of information technology, adding that the PPA already making plans for rolling out the system eventually adopte

However, the electronic transf of prescription pilots have certainly had their fair share of ups and downs over the past year

Reported delays with upgradi the GP software system supplied by EMIS were blamed by some f the hold-ups.

But Pharmacy2U (P2U), one the pilot consortia, insisted that everybody involved in the pilots had to accept part of the blame f the delays, and that it had found EMIS a "proactive and supporti partner".

Then came UniChem and Phoenix Medical Supplies' surprise announcement that the were leaving the wholesaler-led TransScript consortium. UniChem has since joined Flexiscript.

Meanwhile the official start-d for the pilots has been revised several times – initially expected begin in October 2001, the date was then moved to April. The period of assessing the pilots wi now be between June 1 and December 31.

But some progress has undoubtedly been made, with P becoming the first consortium t send actual prescriptions to the Prescription Pricing Authority payment (*C&D April 20, p12*).

P2U said it was receiving prescriptions from four GP surgeries. A second, Co-op own pharmacy is ready to go live as soon as the GP surgery it is link

ith is fully up and running.

"It is everything we envisaged it ould be, in terms of speed of rescribing, accuracy and speed of ispensing and the ability to reate digital signatures," says Daniel Lee, P2U's managing irector.

The TransScript consortium is xpected to follow suit soon fterwards and send live rescriptions from 20 pharmacies ssued by two GP surgeries.

And Flexiscript, its third onsortium, which is still ompleting its beta-testing, was ue to go live in its first harmacy, a health centre-based ndependent, on May 7.

"What's holding us up at the oment is the nature of the rescriptions being sent to us by MIS," a member of the lexiscript consortium says.

He adds that the test rescription sent by EMIS via the lexiscript system appeared to ave differed slightly from the one he PPA had received from ransScript. This needed to be esolved before final PPA pproval.

Meanwhile, an accreditation rocess is being designed by the PA to validate GP and pharmacy ystems and ensure that they meet he minimum requirements ecessary to transmit electronic rescription messages.

So far, Hadley Healthcare's ystem has been approved for the 2U pilot.

Flexiscript says it is continuing o work with EMIS to complete oftware preparation for nstallation at the GP practice. It dds that the AAH/LS2 software s ready to be installed - and then cceptance tested by the PPA - in he first live pharmacy site. NDC nd Moss (Mediphase) solutions re currently in system testing.

For Mr Ball, the creation of an NHS Primary Care Drug Dictionary (PCDD), which can e used by GP and pharmacy ystems to process electronic rescriptions, is an integral part of he ETP project.

"What's holding us up ... is the nature of the prescriptions being sent to us by EMIS"

Drug information from manufacturers and pharmaceutical wholesalers will be combined with information from appropriate authoring groups, to provide, via the PPA, a common dictionary of terms, concepts and information which can be used by GP and pharmacy systems and the general public. A prototype is currently in user testing.

The PCCD, which should be available from December, will provide:

- a common medicines reference for GP and dispensing contractor systems so that the medicine name entered by the prescriber appears to the dispenser
- a common set of definition and data descriptions (medicines) for adoption by public sector bodies, so that information accessed by any party is always presented in the same manner to make it easier to understand, and to be therefore used more effectively
- a supporting framework for departments and agencies to implement electronic record management systems.

The PPA is also project managing a specialist message development team to develop the required messages – these are expected to evolve as the pilots progress.

"We need to achieve a level of satisfaction for all parties involved and have assurance that they (the systems) work together," says Mr Ball.

He is hopeful that the pilots will be completed in the envisaged timescale.

"There is absolutely no doubt we are all gearing up to deliver on our commitment."

The Department of Health says the pilots are making "good progress" and that the fact that live prescriptions are beginning to come through is "a positive step" in achieving the target outlined in *Pharmacy in the Future – Implementing the NHS Plan.*

PharMed, which is part of TransScript, says that "having already run one ETP trial, we understand the complexities involved, and have in response developed a simple, cost effective model that is easy to implement within current timescales".

But Chris Brooker, PharMed's managing director, also put the ball firmly in the PPA's and the DoH's court: "It will only happen if there are robust plans for the roll-out, including a business case and risk analysis, and everybody has agreed to them."

Mr Lee is convinced that "by the end of the year there will be some excellent systems to choose from – the political will is there to make it work."

Others are more sceptical.

Roy Carrington, chief executive of National Co-operative Chemists which is part of Flexiscript, believes the timeframe is unlikely to be met as "we have been held up at every turn".

While Sid Dajani, a member of the Royal Pharmaceutical Society's Council, suggests it won't happen "... unless the data collection and evaluation is flexible enough to cope with the delays".

Mr Dajani is concerned that the late start of the pilots could affect, or even undermine, the evaluations as there might be little time to carry out a comprehensive study.

"The longer these trials take to properly start, the less chance we have of proving the advantages and the less the chance that the Government would be willing to pour funds into IT in pharmacy. Moreover, the Government may see such delays as counter-productive and too much of a problem to roll out."

He is also startled by UniChem's defection to Flexiscript.

"Unichem invested vast amounts of money with the

Continued on page 36 ▶

The Who's Who of the ETP pilot consortia

Consortia	Members
TransScript	● Gehe UK (AAH Pharmaceuticals, Lloydspharmacy, Pharmed) ● BT
Flexiscript	● Boots the Chemists ● National Co-operative Chemists ● UniChem ● Schlumberger Sema ● Microsoft ● Cable & Wireless
Pharmacy2U	● Pharmacy2U ● North West Co-operative ● Hadley Healthcare ● Viacode

◀ Continued from page 35

TransScript consortium before opting for a different model. You would think it would have looked into joining any consortia very carefully before doing so. The embarrassment to the company and wastage of resources cannot be taken lightly by the shareholders."

Despite the indisputably slow progress, interested parties remain convinced of the benefits of ETP.

"ETP can provide the first stepping stone to enable a broader role for community pharmacy within primary healthcare," says PharMed's operations director, Martin Strange.

Mr Brooker adds that ETP is all about pharmacy being at the top table among healthcare professions, rather than sitting on the side.

Mr Dajani believes ETP could help to cut down fraud, increase communications between surgeries and pharmacies, and reduce patient waiting times as well as reducing medication errors due to illegible prescriptions.

And it could help to lower pharmacies' stocks, which would save pharmacists money.

"Other successes would include faster PPA payment processing, better data collection and prescriptions not getting lost," Mr Dajani adds.

Further potential benefits will include pharmacists joining the NHSnet, and the development of shared electronic patient records.

Mr Dajani is, however, concerned about the possibility of different systems being rolled out in different areas.

"We need to make sure that all the solutions are compatible with each other," he says. The evaluators of the pilots, he adds, will ensure this happens.

Meanwhile, Mr Brooker thinks that the Government will have to go for a national system, which may contain elements of each pilot.

Michael Major, chief executive of Enigma Health, remains to be convinced that "the current pilots are the ones that will be adopted eventually".

The PPA is, understandably, more circumspect. It would only say that the final solution should be based on open standards which allow GPs and pharmacists freedom to choose from system suppliers, as long as these conformed with certain standards laid down by the Department of Health.

Making the computer work for you

"It's time to stop the vast usage of pharmacy computers as expensive labelling machines and start using them as tools for medicines management and pharmaceutical care," says Sid Dajani, a member of the Royal Pharmaceutical Society's council.

He sees the dispensary computer as a place for known diagnoses, screening results, daily updates via a web connection regarding product recalls, prices, and product availability.

Moreover it should keep a record of a patient's sensitivities to medicines, adverse drug reactions as well as dispensing errors and how they were rectified.

"Records could then be audited electronically and the primary care trust could pay for the intervention. Pharmacists are competent and do make a difference, but when we are asked to back up what we do, we have very little proof as our records rely on business management rather than medicines management," Mr Dajani says.

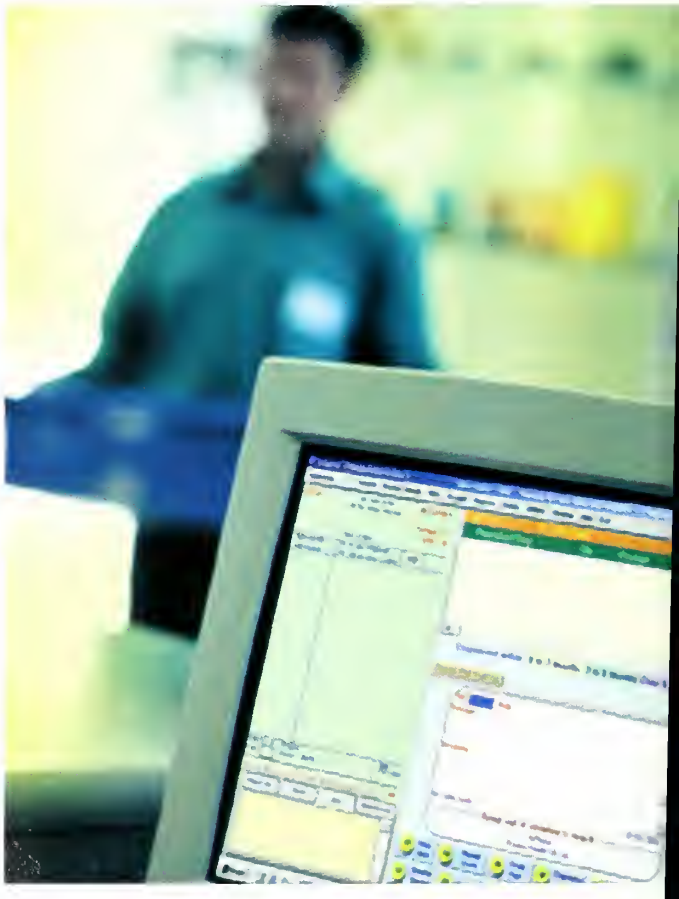
Meanwhile, his call for an affordable EPoS system for the average pharmacy, enabling it to maintain stock levels and have a better understanding of what sells, appears to have been heard – Positive Solutions has recently launched an entry-level EPoS system (JustPos).

"Currently EPoS systems are only good for networking or very busy pharmacies. Otherwise they are just expensive toys and a waste of money."

Coll Michaels, professional services manager at IMS Health, agrees to a certain extent, saying that pharmacists are, by and large, using their IT systems rather passively, such as by collecting PMR updates.

As the host of many pharmacy sites, IMS is finding that the PSNCnet (for the online Drug Tariff) and the *C&D Pricelist* are amongst the most popular services used by pharmacists.

With pharmacists putting increasing demands on their computers, what are systems suppliers doing to meet them?



There also appears to be an increasing demand for a service which allows the remote saving of patient data, such as the NPA's pharmacy dataSafe.

He reckons the most important step in pharmacy IT would be to bring all systems onto a Windows-based platform.

"The problem with DOS-based systems is that they cannot easily interchange information with other Windows-based applications," he says.

In light of the imminent arrival of the electronic transfer of prescriptions , Mr Michaels believes pharmacists will not w to place an order with their wholesaler via a traditional, D based, order transfer.

So what are the systems suppliers doing to adapt to the changing requirements placed their systems?

It has certainly been an interesting 12 months for pharmacy IT. Three ETP pilo have been launched in Englan and one in Scotland, Enigma

Health has brought its new PMR-system, NexPhase, onto the market and NDCHealth is due to phase out its DOS-based products by the end of May 2002.

Over the next few months McLernons, which supplies the Northern Irish market, will roll out its new core product – a Windows-based PMR system.

The fully ETP compatible system will feature electronic product updates, advanced medicines management, comprehensive reporting as well as integrated web access and e-mail links.

ETP is certainly going to be one of the most far-reaching changes facing pharmacists and their system suppliers.

Hadley Healthcare is part of the Pharmacy 2U ETP pilot and is now using its Eclipse system to receive e-prescriptions.

"It's a big advantage to have been involved in the pilots from the beginning, because the expertise our development team has gained will ensure that whatever model the Department of Health decides on, Eclipse users will be among the first pharmacies to receive their prescriptions electronically," says Michele Hulme, Hadley Healthcare's sales director.

Meanwhile, NDCHealth has adopted a different approach. Rather than collaborating with a single consortium, NDC has developed NDC Pharmacy Manager, which is designed to interface with three of the ETP pilots (Flexiscript, TransScript and SCI (in Scotland).

"This will allow more of our customers to take part in these pilot schemes and will enable NDCHealth to adopt the Government's chosen ETP system with relative ease," says Steve Arnold, managing director of NDC.

He adds that "an ETP compatible version of NDC Pharmacy Manager went live on site during February for messages between the GP and the pharmacy, and hundreds of electronic prescriptions have now been successfully dispensed".

Currently, over 80 per cent of the 60 million items dispensed each month in the UK are filled as repeat prescriptions. Enigma Health's new Windows-based system, NexPhase, has been designed with repeat prescriptions in mind.

A unique and patented internet-based repeat prescription process is built into NexPhase. By adding a link so that patients can be reminded to request a repeat prescription from the GP, the pharmacist is taking a lead role in helping patients to manage their treatment and comply with their medication regime. After ordering repeat prescriptions, the patient is automatically led to the local pharmacy site, which gives the pharmacy more scope to sell additional OTCs online.

Meanwhile, NDC has released a new piece of software to help pharmacists manage repeat prescriptions. Repeat Rx integrates fully with the NDC Pharmacy Manager software and provides automatic prompts to enable the pharmacist to request, collect and deliver the prescription on behalf of the patient.

So what's next? NDC says it will be focusing its development on new functionality that will help pharmacists to embrace their new extended role, to provide higher levels of patient care and increase patient care as well as developing profitability.

NDC's new internet-based reporting tool, NDC Information Manager, uses the data collected on a daily basis in the store to provide the pharmacist with detailed reports about the performance of their business.

Hadley Healthcare is due to release the 'Technician Dispensing Check' in the Co-op Pharmacy chain (co-owners of Hadley Healthcare) over the next 12 months. Focused on safety and efficiency, it uses a bar code scanner to alert the pharmacist of picking errors.

Phoenix, meanwhile, is set to launch two new systems over the course of the next 12 months. The first is a new ordering system which, unlike systems provided by other wholesalers, is designed purely and simply as an ordering system. The second is an interactive website that will be available to all Phoenix customers taking up the new ordering system, as internet access will be included.

Meanwhile, both Lloydspharmacy and National Co-operative Chemists are involved in EPoS trials.

NCC, which has never used an EPoS system in its stores, is currently carrying out a pilot in 10- 12 branches. The 12- month pilot is expected to last until autumn.

Neil Slater, NCC's services controller, is keeping an open mind on whether or not NCC will move towards an EPoS system. He says he needs to be convinced about its effectiveness and appropriateness in a pharmacy setting before finally making a decision.

Mr Slater admits, however, that "in terms of an integrated approach it would be nice to be able to also record OTC sales, which is not possible without EPoS".

Lloydspharmacy is trialing a new system in 16 branches, and expects to roll it out to all 1,300 stores in early summer.

Lloydspharmacy's programme manager, Roy Maddison, says the system will bring many benefits to the business, including:

- greater control over the management of stock
- improved data polling
- comprehensive data validation
- powerful and flexible management information
- enhanced merchandising management, giving – among other things – much greater scope for imaginative promotions.

"We see the development of this system as central to our progress as a major competitive player in the industry.

"The system will improve efficiency and accuracy in all areas of our business, from finance to marketing, from buying to sales, in-store and at head office," says Mr Maddison.

"Currently EPoS systems are only good for networking or very busy pharmacies. Otherwise, they are just expensive toys and a waste of money"

Low cost systems are no longer an option

John Davies, Mawdsleys' retail services director, offers some practical and commercial advice on investing in new computer systems

Ask any pharmacist what the essential functions of a good pharmacy computer system are and the list will probably stop after just three items:

- label quickly
- maintain the patient record
- control and re-order the stock.

Any other function, particularly if it slows down the speed of dispensing, is either rarely used or regarded by some as a complete waste of time.

In any case, older systems, many of which are still in use, offer little scope for much else.

That's the DOS era, but can Windows-based systems live up to their promise?

More importantly, how and when does the pharmacist choose between the several systems now being heavily promoted?

Windows-based systems allow more complex functionality and communication than their predecessors.

However, initial attempts at winning over pharmacists were largely unsuccessful. It is only recently that stable, well designed systems have become more widely accepted. Their designers now recognise that they ignore essential functionality at their peril.

"Demand for more complex systems is increasing steadily"

There is no doubt that demand coming from forward thinking pharmacists for more complex systems is now increasing steadily.

Networking capabilities with sophisticated communication functions and, most importantly, higher levels of integration crossing the boundaries between traditional functions in the pharmacy will become the accepted standard.

Obvious examples are the inclusion of OTC medicine sales into patient records, billing procedures built to support local professional activities and many others.

At the same time, the simple idea that a supplier can market a single computer specification suitable for the mass market is becoming redundant.

Pharmacists are likely to be drawn into providing locally negotiated contracts, many of which will require specific software support.

The development of Windows-based systems allows for much more complex, multi-functional activities within the pharmacy, which cannot sensibly be concentrated on the traditional, single user work station located almost always in the dispensary.

Fully integrated and networked, multi-work station computers combining PMR, EPoS, management and communication functions – all designed to enhance profitability – will be required to satisfy the aspirations of the high profile pharmacies of the future.

Systems will also connect to larger networks within the Health Service and the commercial sector. The concept of the virtual head office is emerging from several organisations and this will trigger its own set of demands on the pharmacist's system.

Pharmacy system suppliers face the same difficulties in planning for the future as everyone else involved in community pharmacy.

The absence of any clear and consistent commercial or professional model for medicines management, clinical governance, electronic transfer of prescriptions (ETP) or local pharmaceutical services (LPS) is in danger of slowing down development in these areas – a fact the Department of Health would do well to take notice of.

So where do these uncertainties leave pharmacy owners faced with the difficult prospect of modernising their systems?

How do they move from their present position? When do they make the investment? How quickly will system suppliers be able to respond to demand for new services?

The answer is complex and demanding, both financially and technically.

Those pharmacists investing in a new system must seek absolute reassurance from their suppliers that, although the system may meet all their current requirements, it is designed as the platform on which a more complex and adaptable system can be built.

The more obvious features to be required in the immediate future will include:

- ETP support
- LPS support
- audit for clinical governance
- integrated record keeping for OTC and prescription medicines
- control and management of additional patient services
- commercial data exchanged with suppliers
- financial management
- networks to patients and other health professionals.

Since a pharmacist's wish list will include professional and business functions, the investment in terms of both time and money will be substantial and should be treated in exactly the same way as any other major capital expenditure.

The decision must be based exclusively on commercial advantage and should not join the long list of "services before money" that has bedevilled the progress of pharmacy for such a long time.

The tradition of the low specification, low cost system funded on the back of a deal with the pharmacist's wholesaler is no longer a way forward.

The key judgement in choosing a system provider should depend not on what its system can do now, but on the quality of its vision for the future and its ability to deliver change in a well managed and timely way.

Those pharmacists who make the right choice of supplier with a well developed business plan, which has IT systems at its centre, will be the ones who prosper into the "New Age".

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FREE LEGAL ADVICE

Chemist & Druggist's web site – *www.dotpharmacy.co.uk* – has introduced a service that offers pharmacists free legal advice from a leading solicitors' firm.

The service – dotLaw – is being run with the co-operation of Charles Russell, whose specialist legal fields include pharmacy matters.

Pharmacists are advised to e-mail their questions to – *pharmlaw@ubmint.com* – along with their full name and the name of their pharmacy. The latter two details are for *C&D*'s records only – pharmacists' identities wi be kept anonymous when the answers are published.

All the questions and Charles Russell's replies, which will be available in two working days, will appear on a new dotPharmacy page called dotLaw.

Potters Herbal Medicines has expanded its sales and marketing division with the appointment of **Andrew Blanchette** as southern area sales manager. He joins with six years experience in the health food trade.

Jeff Needham is taking over as managing director of private label pharmaceutical manufacturer Wrafton Laboratories following the retirement of John Budsworth. Mr Needham comes to the UK from the USA, where he was vice president marketing for Wrafton's parent company, Perrigo.

As part of a major restructuring exercise at Photo-Me International, UK general manager **Pierre Buendia** has been promoted to director of the company's global minilab division. His position is filled by **David Palmer,** who joined the company in 1993 and moves up from national sales manager.

Pharmacist puts new meaning into the phrase 'kick ass'

Left hooks, body kicks, reverse punches, right crosses. Blocking your opponent's kicks, weaving around his punches. While some pharmacists are unwinding at home after a hard day at the dispensary, Neela Karve, a pharmacist at Croydon-based Parade Pharmacy, is practising the not so gentle art of kickboxing at the nearby Phoenix Kickboxing club.

Watching Ms Karve and her colleagues go through their paces is a little intimidating: loud thuds echo through the hall as the kickboxers pound the heavy bags – every blow accompanied with a "hisssshh", which partly acts as a breathing exercise. But the atmosphere is friendly and relaxed.

Ms Karve says she has always wanted to kickbox, but was too busy having fun to take the plunge. Around a year ago, she walked past a public hall in Wallington, Surrey, where she was living, saw a kickboxing poster advertising a class inside, and decided to have a go.

"The first class was the scariest – I got there early and saw a lot of burly men carrying wooden staffs. I thought 'I shouldn't be here.'" No need to be afraid. The men were black belts and only practised using the staffs against themselves. Ms Karve enjoyed the class and now trains twice a week, on Tuesday and Thursday. "It's very good for relieving stress," she says.

Neela Karve giving the punchbag what for, a great way to relieve stress

Having earned an orange belt, she is six belts away from the coveted black.

Meanwhile, the club recently held a charity fight that raised £22,000 for the Royal Marsden Hospital, which specialises in treating cancer.

Sold up, now off to sea!

Rotherham pharmacist Andrew Watson, left, sold his pharmacy last September after eight years as a proprietor and is now planning to indulge himself with a bit of sailing, something he always fancied doing.

His original intention was to sign up for the next BT Global Challenge. When he contacted the organisers he was told the next race would not be until 2004, but there were places on the transatlantic Challenge Transat 2002 in August. His plans did not go down too well with his wife and two children, but as he says, three weeks afloat are better than 10 months!

Having coughed up his £4,000, Andrew has now completed phase two of his sail training, which involved a Channel crossing from Southampton to Cherbourg. Along with 15 other crew members he will join one of six 72ft yachts to race the 3,300 miles to Boston on August 25.

This week 1952

Reading through back issues of *C&D*, you can't help but be stru by the fact that some things in o little world of pharmacy have changed beyond recognition... a some not at all.

Fifty years ago, in *C&D May 10, 1952*, Xrayser was pontificating (as he still does) about analgesic drugs, following *C&D* refresher course on the subject. An old *Martindale* listed 20 substances as analgesics, he noted, including abrastol (or calcium betanaphthol alpha monosulphonate), for sciatica ar rheumatism.

"Whatever reputation this and several more may once have had has withered. Synthetic chemica of greater potency have since be devised... the pharmacology of analgesics still presents a difficul problem. In spite of much recen work on the nervous system, the mode of action remains unknown."

Meanwhile eight Council candidates were strutting their stuff at a joint meeting of the fi Metropolitan branches of the RPSGB. Top of the agenda for Mr W S Benjamin was the lack employee representation. "The present Council is a cross sectio of pharmacy 30-40 years ago," proclaimed.

Another protagonist, Mr W Cooper, regretted the "present insidious propaganda" about dispensers (or technicians, as w now call them). Every pharmac trained assistants, he said, but i was suggested that they should undergo examination and be registered, then that was a "dangerous thing".

In 1852 pharmaceutical chemists had had assistants. In 1868 the assistants had become registered chemists & druggist outnumbering the pharmaceut chemists, and have done so eve since. Now some pharmacists asking for a repetition of that s of affairs, said Mr Cooper (wh was presumably a pharmaceut chemist in a previous incarnat

Which judge said you canno look at today's cases through yesterday's spectacles?

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